IN THE CIRCUIT COURT OF THE
SIXTH JUDICIAL CIRCUIT IN AND FOR
PINELLAS COUNTY, FLORIDA
CASE NO.: 97-5968-CI-11

JOHN EASTMAN,

Plaintiff,

vs.

BROWN & WILLIAMSON TOBACCO CORP., individually and as successor by merger to THE AMERICAN TOBACCO COMPANY, a foreign corporation; PHILIP MORRIS, INCORPORATED, a foreign corporation,

Defendants.

BEFORE: HONORABLE ANTHONY RONDOLINO
PLACE: The Judicial Building
545 First Avenue North
St. Petersburg, Florida
DATE: Tuesday, April 1, 2003
TIME: 9:00 a.m. - 11:51 a.m.
REPORTED BY: BETH L. BILLINGS, RPR
Court Reporter and Notary Public
Sixth Judicial Circuit

TESTIMONY AND PROCEEDINGS

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I N D E X T O P R O C E E D I N G S

(9:00 a.m.) P-R-O-C-E-E-D-I-N-G-S

THE COURT: Good morning, everybody.

Are we all ready to bring the jurors in?

MR. LYDON: Mr. Wallace has got one -- 30 seconds behind us.

THE COURT: All right.

MR. CHRISTOPHER: And ten of those 30 seconds is we filed this morning defendants' proffer concerning plaintiff's submissions of substance abuse.

THE COURT: All right.

MR. ACOSTA: Judge, we do have one matter that I forgot about.

THE COURT: Everybody can sit down.

MR. ACOSTA: They filed this -- they filed Dr. Kaplan's report, and so it's part of the public record. So I don't think that should really be open to the public.

MR. LYDON: I agree, Your Honor.

MR. ACOSTA: And we would like to have that sealed, if that would all right.

MR. LYDON: We have no objection.

THE COURT: What do you mean it's been filed?

MR. ACOSTA: Well, they filed --

THE COURT: As part of the proffer?

MR. ACOSTA: No, they filed it previously.

MR. LYDON: I imagine what happened is it was filed as part of the expert disclosure, perhaps.

MR. ACOSTA: No.

MR. DENSON: It was filed as part of the motion to admit that testimony.

MR. LYDON: That's right, respect to his testimony. And remember when we were suggesting --

THE COURT: Right.

MR. LYDON: -- it was appropriate for him to --

THE COURT: Right.

MR. LYDON: -- consider these other substances. We, of course, have no objection with being under seal and that was inadvertent.

MR. ACOSTA: And the same with the proffer that they just made, I think, it would probably be appropriate.

MR. LYDON: That's fine.

THE COURT: We're off the record.

(A discussion was held off the record.)

THE COURT: Very well. The Court is going to grant the motion, seal the reports of Dr. Kaplan

that have been submitted.
Madam clerk, if you will assist me in doing

that.
All right, are we ready to bring the jury in?
MR. LYDON: Yes, Your Honor.
THE COURT: Very well.
All right. Sheriff, let's bring the jury back.
THE BAILIFF: Yes, Your Honor.
(The following took place in the presence and hearing of the jury.)
THE BAILIFF: Jury is in the jury box, seated.
THE COURT: Thank you very much, Sheriff.
Welcome back, folks. We are ready to continue with the defense. Mr --
MR. LYDON: Lydon, Your Honor.
THE COURT: Lydon. I drew a mental blank all of a sudden.
We can proceed.
MR. LYDON: The defense will call Dr. Kaplan.
THE BAILIFF: What's the last name?
MR. LYDON: Kaplan.
THE BAILIFF: If you would, sir, stop here and face the clerk to receive the oath
Thereupon,
ERIC MICHAEL KAPLAN, M.D.,
was called as a witness and, after having been first duly

sworn/affirmed to testify the truth, was examined and testified as follows:
THE WITNESS: I do.
THE BAILIFF: Step this way, please.
Have a seat in the witness chair. Watch your step.
Speak in a clear and loud voice. And there is water there.
THE WITNESS: Okay
DIRECT EXAMINATION
BY MR. LYDON:
Q Good morning.
A. Good morning.
Q. State your name, please.
A. My name is Eric Michael Kaplan, M.D.
Q. And your profession -- profession, sir? Excuse me.
A. I'm a medical doctor and a psychiatrist.
Q. And where do you practice?
A. I have a practice in Lutz, Florida, which just a little north of Tampa.
Q. And you are licensed in the state of Florida?
A. Yes, I am.
Q. Are you married, sir?
A. I am.

Q. You have children?
A. Yes, I have three children.
Q. Would you briefly explain to the jury and tell them about your educational background?
A. Sure. I went to Emory University in Atlanta, Georgia, for my undergraduate degree. I have a degree in biology and anthropology; that was from 1978 to 1982.
And then from there I applied to medical

schools and got into the University of Miami in Miami. And medical school is four years.

And then after medical school, I decided to become a psychiatrist. And to be a psychiatrist you go into a residency. It's a four-year program. And at that time I wanted to stay in the state of Florida and decided that the program at University of South Florida in Tampa was the best program. So I went to residency in Tampa.

Q. Doctor, when did you graduate from medical school?

A. Graduated from medical school in 1986.

Q. And can you explain briefly to the jury what a psychiatrist does?

A. Sure. A psychiatrist is the specialty in medicine that specializes in human behavior. So we are trained to understand both the psychology and the

biology of how people act, what people do.

In addition, we are the specialists that take care of people who have mental illnesses and substance abuse disorders. So we are trained to diagnose and to treat people who have a variety of mental disorders; for example, clinical depression or an anxiety disorder or substance abuse disorders, such as nicotine dependence or heroin abuse or alcoholism, things like that.

Q. And did you train in -- before you got into your specialization, while you were in medical school, in the area of substance abuse?

A. Yes, I did. And this is really typical for all physicians. During the first two years of medical school it's really like high school or college, you sit in classes and professors teach you information about various topics, and substance abuse is one of them. So we learned about the consequences of various drugs and how they can affect the human body and how they work in the brain.

And then the last two years you actually get to work with patients and work on the units in patient units and outpatient units.

So during the third year you go through different rotations. One of them is internal medicine or family practice. And as that relates to substance

abuse issues, you learn the medical aspects, what certain drugs can do to the human body. If someone goes through withdrawal, how to treat that.

And then you also go through a psychiatry rotation. And during that rotation you may work on a substance abuse unit, learning how to diagnose and how to treat people with a variety of substance abuse issues. And you also get experience treating outpatients, working with people in AA and Narcotics Anonymous, and other behavioral and medication treatments for outpatient therapy.

And then finally the last year you get to pick electives. If you are interested in a certain topic, you get to pick extra education in those topics. And, again, since I was real interested in psychiatry I had some extra training as it relates to various substance abuse issues.

Q. Did you train anywhere other than at Miami?

A. For medical school in the last year I did what

they call an externship. What that means is you get to go to another school, another medical center, if they have a certain area that you are interested in; you get some additional training, or, perhaps, if you are interested in doing your residency in another state, you get to see what it's like before you decide to go there.

3910

And yes, I did an externship at the University of California Davis, which is located in Sacramento, California.

Q. And what kind of work did you do while you were at the University of California Davis?

A. I participated in an inpatient-psychiatric unit, so patients were admitted there who had a variety of mental disorders like schizophrenia, people with severe depression. And there were also people on this unit who suffered from a variety of substance abuse disorders; people with alcoholism, people with narcotic dependence, like heroin; people who were abusing cocaine. Some of those people with the various mental disorders and substance abuse disorders were smokers and some were not.

Q. Did you receive any awards during your course of medical school concerning psychiatry?

A. I did. At the University of Miami for each specialty they give an award to the med student who they feel performed the best from the graduating class, so I received the award for psychiatry.

Q. And after medical school, what did you do?

A. After medical school I -- during medical school I applied for residencies and was fortunate enough to get into the program at the University of

3911

South Florida, so I moved to Tampa. And I completed a four-year psychiatry residency at the University.

Q. An did you receive any awards during that resident program?

A. I did. My last year I was chief resident, which is basically a position that they ask you to take where you help teach. You teach med students. You teach residents. You organize some of the programs. So I was given an award for the resident who they felt did best in the graduating class, and also I was involved in a research project.

At that time AIDS was becoming a big issue for our society, just kind of started. So I put together a paper on how to teach residents various psychiatric aspects of HIV and AIDS infections, so I received an award for that.

Q. Did you continue to work in the area of substance abuse during that residency?

A. Sure. Actually, that's when it really started to increase. The first year of a psychiatrist's training really is involved in internal medicine and neurology. You don't do a lot of psychiatry. So the first year I was an internist on various medical wards and worked as a neurologist.

And what you do in those rotations, as it

3912

relates to substance abuse issues, is you educate patients regarding any substance abuse issues they have. If there is medical aspects, you treat it. If there is withdrawal issues, you treat that also. And in the last

three years you really focus on psychiatry.
Now, as that relates to substance abuse issues, I participated in inpatient units where people were admitted, so they actually slept in the hospital, with a variety of substance abuse issues. Most of them suffered from alcoholism. Cocaine dependence was a big problem. Heroin dependence was a big problem. Some people abused hallucinogens, like LSD. Some of the people were smokers, some were not. So I received training and experience there.
In my last year as chief resident I actually supervised one of the units, taught the med students and residents. And then as an outpatient I would treat people on an outpatient basis either after they were discharged from the units or people that never were admitted to help them overcome a variety of substance abuse issues.
Q. When you completed your residency, what did you do?
A. Well, after residency -- during residency I met my wife and we had a son at that time, so we decided

to stay in Florida. So I did several things. I started a private practice in the north part of Tampa.
I also was fortunate. They were opening up a new hospital, a new psychiatric hospital in Pasco County called Charter Hospital of Pasco. And I was fortunate enough they offered me a position to run their adult-inpatient unit.
So I ran that unit. I treated patients in that hospital. I had an outpatient practice. And I also, ever since I completed my residency, I have stayed on faculty. So I'm a clinical associate professor at the University, and I have been teaching med students and residents on a volunteer basis ever since.
Q What about your duties at Charter Hospital? Do they involve substance abuse?
A. They have. There is a -- or there was, because the hospital is not there anymore, but there was an inpatient alcohol and drug program. They called it the ADP.
So I was treating physician for many patients who went through that program. After approximately two years after the hospital started, they asked me to actually run the program. So for a period of four or five years I was the service director of the alcohol and drug program.

And my responsibilities, in addition to treating my own patients there, was to supervise the program, to help train the staff, to help develop different tracks, depending on the needs of the patients in that hospital.
Q. All right. And up to this point in time or through that point in time, did you have the opportunity to treat people interested in quitting smoking?
A. I did.
Q. Approach that subject?
A. Sure. Well, it really depended on their desire.
A good number of people on the alcohol and drug program -- and even on the psychiatric units -- were cigarette smokers. Some of them had no interest in

stopping. We would educate people about potential health risks, et cetera, of smoking, but if they had no interest, we really didn't address it.

If they had interest, a desire to change their smoking behavior, sure, we tried to help them stop.

On the alcohol and drug unit, we had a smoking cessation track, which means that wasn't the main reason they were there, but in addition, if they wanted help in stopping smoking, we provided additional types of therapies, both behavioral and medication therapy. And

I helped with other professionals to design the smoking cessation track at the hospital.

In addition, there was a hospital that was simply substance abuse, the whole hospital was. Again, no longer in business, but it is called the Care Unit of South Florida, and it was a freestanding substance abuse hospital across the street from the University. And I was their psychiatrist. So if they needed a consultation from someone, I assisted them.

And, again, they had a smoking cessation track for patients who were admitted there with other substance abuse problems who were smokers, who were interested in stopping. And, again, as a part of a group, including social workers and psychologists and what they call CAP, certified addiction professionals, I was part of a group that helped design the smoking cessation track.

Q. Now, talking specifically about Charter, and during the period you were director, how many patients came through the substance abuse unit during that period of time?

A. I would not really be able to recall the exact number, but literally thousands of patients over the years that I was there.

Q. How many did you personally treat?

A. Oh, that they were my patients? I would say -- again, I can't be accurate on the exact amount, but I would say approximately 600 or so patients I treated as their own doctor, you know, over the period of years that I worked out of at Charter Hospital in Pasco.

Q. And do you have any idea how many of those people may have been interested in the smoking cessation program?

A. I'm gonna kind of guesstimate here because, again, I can't be exactly sure, but I would say of those 600, perhaps 400 or so were cigarette smokers, maybe a little more. And of those people, probably half of them were -- had some interest in stopping smoking. And, again. Depending on their interest and their motivation, we certainly tried to assist them.

Q. Aside from Charter Hospital, did you have any other practice?

A. Yes. Well, I had my outpatient practice, so I would usually six days a week go to the hospital in the morning and then in the afternoon, Monday through Friday, see outpatients. Some of them came to me after they left the hospital, and other patients just always were outpatients. They never were admitted to the hospital.

As I already stated, I helped provide consultation at Care Unit of South Florida. And then as a psychiatrist, we often do what we call consultation work in medical hospitals.

So let's say a surgeon or an internal medicine physician has a psychiatric question; someone they are treating is severely depressed or they're having substance abuse issues or withdrawal, they may ask a psychiatrist for some guidance. So I provided consultation at several hospitals, Tampa General Hospital, University Community Hospital, which is just north of the University. And there was a psychiatric hospital at the University that I consulted at at times.

Q. You mentioned that you teach. Where is it that you teach?

A. At the University. University of South Florida Medical School has different departments. So the department I trained at, the psychiatry department, I helped teach medical students who rotate through there and the psychiatric residents who rotate through the program.

Q. Doctor, I think the jury has heard about the term "board certification." Are you board certified in any particular area?

A. I am. The primary board for psychiatrists is

called the American Board of Psychiatry and Neurology. So I am board certified under that.

I also have approved under the American Board of Forensic Medicine and the American Board of Disability Analysts.

Q. What did it take to become board certified in psychiatry?

A. Well, first you have to complete a psychiatric residency. So after your four years of residency, you are what they consider board eligible. So you can practice psychiatry, but then you have to actually sit for the examination.

During your first year outside of your residency, you can take the written part, which is both psychiatry and neurology. It includes substance abuse issues. I took that test as soon as I was able to and I passed it.

And then once you passed it, you can sit for the oral boards, which means you interview patients in front of real live professors and they throw you a whole bunch of questions. And I passed that also.

And once you pass both sections, now you are considered board certified. In the United States, approximately half of the psychiatrists who practice are board certified. Half have not completed the boards, so

they are considered board eligible.

Q. You mentioned you are also certified as a forensic examiner?

A. There is an organization of clinicians who are interested in forensic work.

Q. Explain?

A. Well, what we are doing here is actually an example. Forensic, for this purpose, means somehow it is related to the law. You may see television programs that look at forensic work, that's more criminal cases. But what I do is I am involved, as we are here today,

when there is a medical-legal issue, and they request a psychiatrist's impressions or consultation, then I get involved in some of these cases.

So I am a member of the board for that, which is the American Board of Forensic Medicine.

Q. All right. Have you ever testified previously in a tobacco case as you are doing today?

A. I have.

Q. On how many occasions?

A. This would be my fourth occasion. Two of them were in Miami, and including today, two in St. Petersburg, Florida.

Q. And which side retained you in all of these instances?

A. In all four cases I have been an expert for the defense in these cases.

Q. Now, can you tell the jury a little bit about your current private practice, just describe it, please?

A. Sure. It's changed over the years. I no longer go to hospitals to do consultations. I still have my outpatient practice, and I treat patients with a variety of mental disorders and substance issues. I have an office in Lutz, Florida.

In addition to that, I became interested in doing research over the years, mostly focused on psychopharmacology, which means how medications affect brain chemistry. For example, antidepressant medications, I do a lot of work with. So I have done some research. I've published on those areas. And I lecture extensively. I usually lecture weekly.

I teach family practice doctors and internal medicine doctors, and psychiatrists, various issues in regards to how to treat mental illnesses.

In addition, as we are here today, I am involved in some forensic cases. So I will give expert witness testimony in regards to my impressions as it relates to various issues. Some of them are tobacco-related cases, and other ones have nothing to do with tobacco cases.

Q. Regarding the patients you see, that would be called your clinical practice; right?

A. Correct.

Q. How many patients do you currently see in your clinical practice?

A. I currently have approximately a thousand outpatients.

Now, many of them are doing quite well, so I only see them for checkups, you know, every four-to six-months. If they are not doing well, I certainly see them more frequently.

Q. Do these include people who have substance abuse problems?

A. Sure. They include people with alcoholism. I treat cocaine dependence, heroin dependence, LSD; some of them are smokers. Some of them are interested in stopping, so I try and help them.

Other people are not interested or not smokers. So smoking sometimes is an issue, sometimes it's not. And then I treat a lot of people with depression, and manic depressive disorder, panic disorders, a variety of mental illnesses.

Q. If smoking isn't the reason a patient comes to see you, how does a smoking issue come up?
A. Well, I am a physician, and I certainly am

interested in my patients being as healthy as possible. So if they are smokers, I certainly discuss some of the potential health risks of smoking. And like other behaviors that may have some risk to them, I recommend they make some changes.

If they are interested, then I certainly try to assist them in changing a variety of behaviors, smoking being one of them.

Q. You mentioned behaviors. Do you treat patients with dependencies that aren't related to ingesting substances?

A. Sure. We can call them dependencies or habits or compulsive behaviors, but the answer is yes. There are a variety of repetitive behaviors that people do that can cause some distress in their life, that can cause problems in their life.

I treat people who are gamblers, that can cause a lot of problems in their financial and social lives.

I treat people with compulsive habits, like excessive shopping, sexual compulsive behaviors, compulsive overeaters.

There is a lot of information in the media today in regards to the consequences of obesity. So I treat people who have difficulty controlling their

eating habits.

Sometimes they have disorders like bulimia or anorexia. And all of these disorders are unrelated to actually ingesting a substance, except, of course, food, when it comes to eating disorders. So, yes, I try to help those people change their behaviors.

Q. You mentioned your forensic work. Aside from doing work such as you are doing today, what other kind of forensic work do you do?

A. Well, it varies.

Again, one of my real interests is psychopharmacology, how chemicals, drugs, medications, affect brain chemistry. And I have been an expert for the State of Florida on several cases where people committed crimes, and the defense for them was "it wasn't my fault. The medication made me do it."

Some you may be familiar with the medication Prozac. There were a series of Prozac defense trials years ago, and I was an expert for the State of Florida on two cases which involved adolescents that were -- who committed crimes who were on the medication. So I have been involved in that.

I have also been involved in a lot of disability cases. If someone has a psychiatric illness, let's say, major depression or bipolar manic-depressive

disorder. And if they say they can't work as a consequence, I may perform an examination and give my impressions on how that illness affects their ability to work in certain professions. So I do some of that kind of work, too.

Q. Doctor, since completing your residency and your education, your formal education, have you

continued to obtain training in education in the field of diagnosing and treating substance abuse or substance dependence?

A. Yes, I have. And this is common for all licensed physicians in the state of Florida. You have to each year involve yourself in a certain amount of extra education to keep your license up. So I have done that. And a lot of what I have done is focused on substance abuse issues, going to seminars. I certainly try to read all the newest published data as it relates to various substance abuse disorders; some of it related to smoking and nicotine, some of it not.

In addition, I teach a lot. And in preparation for some of my lectures, I have to do some reading and research. So, sure, over the years I have done my best to try to keep up with the literature.

Q. And in keeping up with the literature, did I hear you say that you do include nicotine dependency?

A. Yes, I do. As I'm here today, I'm going to be asked to give some of my thoughts and impressions as it relates to nicotine and brain chemistry and smoking. So, sure, I try to keep up on the published literature as it relates to nicotine.

Q. Over the years, how many patients have you treated who were cigarette smokers and wanted to quit or were interested in quitting?

A. Over the years, close to a thousand. A lot of them were inpatients. Some of them were outpatients, but I would say, you know, numerous hundreds, close to a thousand.

Q. Now, how is a clinical psychiatrist such as yourself specially qualified to discuss a person's ability to quit smoking?

A. Well, I think we are qualified based on our experience and our education.

As I stated previously, we are the medical physicians that are experts on human behavior. People who use and abuse substances, who are dependent on substances, that's a behavior. And in order to stop that behavior, to make changes in one's life, we address the psychology behind interest, motivation to change. We also address the biology. So how do drugs affect brain chemistry, how do those changes affect one's

interest, desire to make changes.

So we are trained in both the psychology and the biology of substance abuse issues and how to help people change their behavior if they are motivated, if they are committed to changing such behavior.

Q. Of the nearly thousand smoking patients, how many actually ask you for help to try to quit smoking?

A. I would say approximately 50 percent of those patients ask for some guidance or assistance in stopping.

Q. What did you do to assist them, generally?

A. Well, I usually try to involve them in some of the recommended treatments. The U.S. Department of Health and Human Services recommends a combination of counseling and pharmacotherapy, medication management. And I think that's correct, and I abide by that. So, number one, I really try to get them motivated.

My experience has been that an overwhelming

majority of my patients already have a lot of knowledge about the fact that this smoking behavior can be associated with various medical illnesses. But still I re-educate them, I want to get them remotivated for reasons to change.

In addition, I give them social skills training. I teach them techniques to help them change

3927

behavior, exercise, relaxation techniques, self-hypnosis, things like that.

And then there are a variety of medication management techniques that you can mix with the counseling component to help them stop smoking. Some of this involves nicotine replacement. Some of it involves other ways of making the quit attempt more successful.

Q. What are the most fact -- important factors you believe in -- in assisting people to successfully quit smoking?

A. Well, I think the two most important factors -- and I'm not the only person who thinks this, this is well documented. And this is not just true for stopping smoking. This is true for changing any behavior that we do repetitiously. You have to be motivated. If you don't want to change, quite simply, most people are not going to change. You have to be motivated. You have to have a strong desire to change. And, number two, you have to be committed. You have to be committed to involve yourself in a plan of action to change your behavior.

So motivation and commitment are the two most important factors for people that are successful who stop smoking and people that are successful, to be honest, in really changing any type of behavior.

3928

Q. Doctor, you talked about your interest in psychopharmacology. Can you explain just what is psychopharmacology?

A. Psychopharmacology is the study of how substances, chemicals, affect brain chemistry; and then how that chemistry actually affects human behavior.

Q. And what's been your involvement in that field? What have you done?

A. Well, I have always been interested in how medications help treat people who have substance abuse disorders and mental illnesses.

Over the years, as I stated, I have been involved in research. I've conducted some research on various antidepressants to treat depression before they were actually released on the market.

You may have heard of medications like Paxil and Zoloft. I've done some research on those. And then I've also done some research and published on various issues. A big interest of mine has been the issue of withdrawal. Can people get withdrawal reactions from substances?

And more importantly, is it only addictive or dependence-producing substances?

I published a series of papers on antidepressant medications, which clearly are not

3929

addictive, but certain ones, when you stop cold turkey, you can get a really serious withdrawal reaction. So I published and done some research on the issue of

withdrawal as it relates to, quote, nonaddictive medications."

In addition, I have done a lot of lecturing, a lot of teaching as it relates to how we treat psychiatric and substance abuse disorders. Mostly psychiatric disorders using various medications and psychotherapies.

Q. Have you most recently drafted some protocol for a new research in this area?

A. Yes, I just -- just started over the last month. There is an interesting new medication just released called Strattera, and it's the first nonaddictive medication approved by the FDA for attention deficit disorder.

It can happen in adults, but usually we see children, adolescents have ADD, or attention deficit hyperactivity disorder. And this medication works on a chemical called norepinephrine. I think we will probably discuss this a little later, but the point is I'm just in the beginning parts of putting together protocol, kind of the rules behind the research, to see is Strattera helps people who are smokers successfully

stop smoking.

Q. Now, let's get specifically to what you were asked to do in this case. What was that?

A. Well, I was asked to give my professional opinion, impressions in regards to numerous aspects of Mr. Eastman's life as it relates to smoking, history, quit attempts, ability to stop, any evidence of psychiatric illness, aspects of Mr. Eastman's personality characteristics, things like that. So I was basically asked to give my impressions as a psychiatrist in regards to numerous issues regarding Mr. Eastman's life.

Q. And, Dr. Kaplan, on the opinions that you're going to render today, have you formed those to a reasonable degree of medical probability?

A. Yes, I have.

Q. What did you do -- what did you review in order to form your opinions?

A. I reviewed a lot of information. There are a lot of depositions in this case. Mr. Eastman had three depositions. Many of his wives had depositions, family members, friends, his treating physician, some of them at deposition, so I reviewed all that. Literally thousands of pages. I reviewed all the medical records that were available. Many had nothing to do with

substance abuse issues. Other ones did describe the smoking behaviors. So I reviewed the actual medical records. I reviewed trial testimony that you have all heard in regards to Mr. Eastman during the case. And I actually interviewed Mr. Eastman. I performed a psychiatric examination in the midpart of February on Mr. Eastman to gather additional information to help me make impressions and opinions regarding this case.

Q. And why is it that you did this examination?

A. Well, it's certainly always helpful if I have the opportunity to interview a person to hear from them, their history, to try to evaluate motivation and commitment to change behavior. To understand information in regarding to quit attempts if there were,

to evaluate one's thinking abilities. Does a person have the intellectual abilities to make decisions in regards to changing behavior? What kind of access to information do they have in regards to health risks?

So I asked if I could perform an examination. And in addition to all the other sources of information I had, I included my impressions of the examination and then I put together a -- an examination report that discussed a lot of my impressions.

Q. Where and when did you examine him?

A. It was -- let's see, the exact date was

February 15th of this year. And I met with Mr. Eastman at his apartment. They have like a social hall area, to make it more convenient for Mr. Eastman. So it was myself, Mr. Eastman, and then per either his wishes or his attorney's wishes, his attorney, Mr. Acosta was there. And there was an attorney for the defense also there, and they also videotaped the examination.

Q. All right. Is that the usual way in which you conduct a psychiatric examination?

A. No, it's a little unusual. I mean in a perfect world I would prefer just myself and the person I'm interviewing in a closed room where we can converse. But given, you know, some of the unique issues in regards to some legal cases, you know, I felt comfortable having other people there.

Q. Now, before I ask you specifically about Mr. Eastman's smoking behavior and his ability to quit and your opinions in that regard, do you have opinions generally about -- based on your experience and education about why people smoke cigarettes?

A. I do.

Q. And have you reflect -- excuse me -- prepared a slide or an exhibit which summarizes those opinions?

A. Yes, I have.

MR. LYDON: Can we have demonstrative Exhibit

1, please

BY MR. LYDON:

Q. And is this the exhibit that, Dr. Kaplan that you directed?

A. Yes, sir, it is.

Q. And can you explain just what you have set forth there?

A. Sure. This is a -- a slide that describes why people smoke. It may seem a little common sense, but, you know, when you ask smokers what do they like about it, why do they smoke, they will describe various things. The first is nicotine. Cigarettes certainly contain nicotine. Nicotine is psychoactive, which means it binds to receptors in the brain, and as a consequence, people get various sensations.

So from nicotine, some people will say I feel more relaxed and some people will say I feel more energized. Some people will say I can focus and concentrate better. People like those feelings, so nicotine is certainly one of the reasons why people smoke.

Taste. If you ask people that are smokers if they enjoy the taste or the flavor of cigarette smoking, some people say, yes, they do.

Feel. Fancy name for this is tactile, having

something in your hands, in your mouth, around your lips, people enjoy that sensation.

Relaxation. Feeling relaxed. Now, as I already stated, nicotine itself can actually cause a relaxation feeling, but in addition, the actual behavior of smoking is relaxing for a lot of smokers, so that is part of the reason. A lot of people smoke more when they are in stressful situations to relieve stress.

And finally, social interaction is important for people. We're human beings like to be around other people generally. So cigarette smoking gives some people a break. They're part of a group. They have an opportunity to talk about what they saw on TV and sports game, and a war that's going on, their relationships. So it gives them an opportunity to interact with other people and a lot of people find that pleasant. So these are all various reasons why different people smoke cigarettes.

Q. And did you make the observation that all these have something in common?

A. Yes, they do.

Q. And what is that?

A. Well, what they all have in common is that all

these reasons are pleasurable to people.

MR. LYDON: Could we have Exhibit 2.

BY MR. LYDON

Q. And this is also your exhibit?

A. Yes, it is.

Q. And so it's your opinion that in common with all five of these factors, pleasure is a commonality?

A. Sure. And that's not just unique to smoking cigarettes. Most of the behaviors we do repetitiously are habits, we get some kind of pleasure associated with those behaviors. So like other habits, cigarette smoking is often associated with the sense of pleasure.

Q. Nicotine, just what -- what about nicotine? Is that the main and only reason that people smoke cigarettes? Can you explain it a little further what the role of nicotine is?

A. Sure. Nicotine is found in cigarettes, and certainly is one of the reasons why people smoke. As I stated previously, some people get a sense of relaxation. Some people get more activated, energized, some people focus get better, but nicotine is certainly not the only reason that people smoke.

If nicotine was so wonderful, we would have people abusing nicotine replacement therapies. Since 1984 we have had methods of getting nicotine outside of

cigarette smoking into people's bodies. They have the gum and the patches. There are nasal inhalers. Most recently you might have seen some commercials for a nicotine lozenger. You don't see people abusing these nicotine replacement therapies. You don't see people, you know, purchasing them to get high off of them. So that's one reason why I don't believe that nicotine is the reason people smoke.

In addition to the issue of the replacement therapies not being abused, the replacement therapies,

to be honest, are not all that successful. If you look at studies where we give people patches or gums that contain nicotine, the success rate after a year is not much better than placebo.

So, again, if the only reason people are smoking is to obtain nicotine, you would expect a much higher success rate from nicotine replacement therapy. So for those reasons -- you know, again, I'm not saying nicotine is not part of the reason people smoke, sure it is. But is it the only reason? No, it is not. Is it the main reason why some people smoke? It's not even the main reason why some people smoke. It may be the main reason why other people smoke.

Q. Doctor, of the many patients that's you -- hundreds, I guess you have indicated you helped quit

smoking, how many of them -- well, of those that came to you or that you discussed quitting smoking with, how many have been successful?

A. It depends. I can kind of split it two ways. If I have a patient who is really motivated, who is committed, we are pretty successful. About 75 percent of people will stop smoking and be successful. If I have a patient who's kind of hoe hum about it, maybe they're there because their wife or their husband or their kids want them to stop, but they don't really want to stop, they're not very committed, they're not very successful, probably only about 25 percent of people actually stop smoking. So it depends on their level of motivation and commitment.

Q. Do you have knowledge regarding the number of Americans who have quit smoking between the years of 1965 and 1995?

A. Yes, I do.

Q. And have you prepared a demonstrative exhibit for the jury that reflects those numbers?

A. Yes, I have.

MR. LYDON: Can we have No. 3, please

BY MR. LYDON:

Q. And can you explain just what you have summarized on that exhibit?

A. Sure. I summarized some information that comes from various sources; the Surgeon General's report, the American Medical Association. Number 1 says over 50 million Americans have successfully quit smoking.

Number 2 -- and this is kind of conservative number, 1.5 million Americans quit smoking each year. And finally, half after all people who have ever smoked have successfully quit smoking cigarettes.

Q. And how have most of these former smokers successfully quit?

A. The overwhelming majority of them -- they just quit by themselves, they don't go for professional help. And they just make a decision finally for whatever reason in their life to stop and they are successful.

Q. And did you prepare an exhibit that summarizes what you found in that respect?

A. Yes, I did.

MR. LYDON: Can we look at No. 4, please.

BY MR. LYDON:

Q. And does this set out how people have quit?

A. Sure. And I'm going to actually just skip for second. No. 2, that's the number I was talking about, which I find real interesting. Over 90 percent of people of former smokers have quit on their own, you

3939

know, without seeing a psychiatrist or a -- an addiction specialist or any kind of professional. So that's interesting.

No. 1, we have various methods to assist people who are interested in stopping. We have discussed that; nicotine patches have been out since I believe '92. Nicotine gum has been out since '84. Various behavioral therapies; exercise, relaxation, social support, encouragement have been available.

And, again, as I stated previously, you have to have someone who is interested in stopping to be successful. So a person is motivated and committed, those are the most important factors for a person being successful in their quit attempt.

Q. As a psychiatrist, how would you interpret the phrase; I would like to quit, but I can't?

A. Well, as it relates to cigarette smoking, I have heard that from people. And generally when you ask them further questions, what they're really saying is; it's hard, I find it very difficult to stop smoking cigarettes. Which is true. I mean, when you think about it, let's just say if we take an average one pack a day smoker, that's 20 cigarettes a day and let's say someone's smoking for years, and let's say they enjoy it. They're doing something 20 plus times a year for

3940

years that they associate with pleasure, with enjoyment. It can be hard to stop that.

If you enjoy something and you do it that frequent, it can be really tough to stop. It's not impossible and people do all the time. But the point is people say to themselves, you know, it's really difficult to do this. I'm not so sure I want to make that change. So when people say; I can't stop. And you really ask them and you push them and you ask them questions, what do they really mean by can't? What they generally mean is it's hard and I don't really know right now if I'm really committed to change my behavior.

Q. All right. Is that statement "I can't" do whatever it is, unique to smoking?

A. Oh, not at all. People often say I can't change a lot of behaviors. Again, don't get me wrong. It's hard to change behavior; to lose weight, to start an exercise program, to watch less television, you know, things that we may consider not necessarily healthful, so we want to make some changes.

We human beings struggle with this all the time. And it's not that we can't, but it can certainly be difficult. It can be a challenge.

Q. Isn't nicotine one of the reasons, though, that smokers find it hard to quit?

3941

A. I think nicotine is one of the reasons why people smoke, and, yes, some people may miss some of what they consider benefits of nicotine. But it is not the only reason. And certainly, nicotine and cigarettes does not stop or inhibit people from stopping if they're motivated.

Q. Well, can you explain further how nicotine works in terms of stopping?
A. In -- I'm sorry, can you repeat the question.
Q. Yes. With respect to nicotine and its role in making it difficult for people or harder for people to quit, what role does nicotine play?
A. Well, I think it's kind of a two-fold role, to repeat myself, people find the feeling from nicotine pleasant, so they're going to have to give up something that they find pleasant.

In addition, some people who stop smoking may have some withdrawal symptoms. Withdrawal can be found both from substances that can cause addiction or dependence, and as I stated previously, it can also be found in drugs unrelated to addiction or dependence.

Some of the symptoms of withdrawal from nicotine can include feeling antsy, angry, irritable, moody. Sometimes people have some difficulty focusing. Sometimes people get more hungry, sometimes they have

some difficulty getting to sleep.

Now, there is a variety of studies looking at the issue of withdrawal from nicotine. And interestingly, over half of the people in some of these studies, Dr. Henningfield's work shows that they didn't have withdrawal symptoms, and approximately half did.

Withdrawal from nicotine is generally short, approximately a week or two in terms of the most intense symptoms. Mild, people don't miss work from withdrawal from cigarettes. They don't miss important family gatherings, things like that.

And interestingly, this is different from nicotine than drugs like alcohol and heroin. The amount that you smoke and the duration that you smoke. Let's say you smoke for 40, 50 years. That's not related to the risk of withdrawal. So a person who may smoke a half a pack for a year may have the same withdrawal as a person who smoked 50 packs -- one or two packs a day for 50 years. The duration and the amount is unrelated to the risk of withdrawal.
Q. Are there other behaviors that are difficult to quit from your experience?
A. Oh, sure. I mean, again, any type of behavior that we do a lot and that we find pleasant can be very difficult. Some of it involves substances. I'm a

coffee lover, and it can be difficult to stop drinking coffee if you really enjoy it and if you enjoy the caffeine.

Behaviors unrelated to ingesting substances; gambling, compulsive sexual behaviors, compulsive spending, certain eating disorders. Again, these can be a real challenge to change. But people can make changes in their life. They can choose healthier behaviors if they're willing to really commit themselves to a program, a plan of action.
Q. Doctor, can a person rationally decide, "I don't want to stop smoking. I enjoy it". Is that a rational decision?
A It is rational. It may seem a little silly that someone would make that choice, but people do make that choice. It is rational to say I'm going to continue to smoke cigarettes, even if you are fully

aware that there are some health risks associated with it. I don't believe it's a healthy decision. But this is not uncommon. People make rational decisions that are not healthy all the time. I do it. My guess is almost everybody here in this building has done it at some time in their life. It's a sunny day here in St. Pete. People come to our fine state to lay out in the sun and to get a sun tan. I have had patients who

have had skin cancer. They have had surgeons remove skin cancer. And they were clearly told you need to wear more clothing and put on, you know, sun block and not lay out in the sun. But they lay out in the sun because for them the pleasure they get out of that is worth the risk. Not healthy, but it's rational.

Look at food choices we make. I have treated people who were admitted to the hospital for a heart attack, a mild cardiac infarction. Doctors clearly educated them on the fact that they needed to lose weight, not just weight, but what they ate. I have had patients go to Kentucky Fried Chicken on the way home from the hospital. You know, not a healthy decision. But, you know what, they decided for their life that the pleasure they got out of that was worth the risk.

So to summarize, people make rational decisions that may not be healthy, but in their mind, they come up with the reasons they want to do this, and they continue.

Q. Now, we have -- the term addiction has been brought up from time to time in the course of this trial. Do you use the term addiction in your practice?

A. When I treat patients I use the term addiction because if you ask the average person on the street what addiction means and what dependence means many more

people are familiar with the term addiction. You see it on TV, you read it in newspapers, magazines. So when I treat a patient I want to talk the language they understand, I will use the term addiction.

Q. Why don't you use the term addiction in a medical context or in dealing with other psychiatrists?

A. Well, for several reasons. If I also met 100 people on the street and I asked you "what is your definition for addiction"? I'm going to almost get 100 different definitions. There is so many different definitions for addiction, not only with nonprofessionals, even professionals you ask them a definition they will give you different ones. So there's not a lot of consistency in the definition.

In addition, for many years the term addiction has had some negative connotations. People have looked at the issue of addiction as weak willed, maybe some illegality, illegal acts. And we certainly don't want to connect those kind of thoughts with a diagnosis.

So for those several reasons psychiatrists have used the term dependence instead of addiction. And in that way there are very specific criteria of what is considered dependence producing. So when I talk to another psychiatrist, another internal medicine doctor, and I use the word dependence, we both know what we're

talking about and then again in addition the term is not associated with illegal acts, weak will and things like

that, so it is less negative kind of behavior to the term.
Q. Using the term -- the common term addiction, can cigarette smoking be addictive?
A. Yes, cigarette smoking --
Q. In a --
A. Sure, it can be considered addictive, sure.
Q. What would psychiatrists use to describe nicotine or cigarette smoking?
A. Well, if we are going to look at a diagnosis, the term would be nicotine dependence. That's the term that we would use.
Q. Is there a manual that psychiatrists use for diagnosing substance dependence?
A. Yes. It's called DSM-IV.
Q. And what's the current version?
A. We are in the fourth edition. It's actually called DSM-IV-TR, so that stands for the Diagnostic and Statistical Manual, DSM. And we're in our fourth edition text revised. The words are not important, but this is the most recent version of this manual.
Q. That's the book I'm holding up here?
A. That's the current version, yes.

Q. And this is a manual that psychiatrists use for diagnosing not just substance abuse, but mental disorders as well; is that right?
A. Correct. Actually not just psychiatrists. This manual is used by psychologists and other therapists, social workers, certified addiction professionals. This is the manual that professionals use to see what are the criteria to call someone depression, bipolar disorder, alcohol dependance. So it's used by many professionals.
Q. Who actually prepared the DSM-IV-TR?
A. The manual is actually prepared under the American Psychiatric Association. And what happens is the APA will ask clinicians who have expertise in areas to meet as groups, committees to go over their most recent literature and then to come up with any changes that they feel are warranted based on research in the diagnostic criteria.
Q. And does DSM-IV refers to the term dependence; is that correct, with respect to substances?
A. Yes, it does. That's one of the diagnoses that someone can have.
Q. Is nicotine one of several substances for which a diagnosis of dependence can be made?
A. Yes. There are a wide variety of substances

where you can use that diagnosis, nicotine being one of them.
Q. What are some of the others?
A. Alcohol, cocaine. For heroin, that would be considered an opiate. So for example a doctor might describe Percocet for someone who has pulled back. That's an opiate. But so is heroin. Hallucinogens like LSD can be an example. So there are many more than that, there are many.
Q. Did you prepare a portion of a chart from DSM-IV that compares the differences between diagnosis for various substances including nicotine?
A. Yes, I did.

MR. LYDON: Can we have No. 5, please.
BY MR. LYDON:
Q. Is this taken from DSM-IV-TR?
A. Yes, it is.
Q. And it's a partial part of that table No. 1?
A. Yes. This is a chart that looks at the different types of substances and some of the different diagnosis that are found in DSM-IV.
Q. What do the X's on this chart represent?
A. The X's represent that there is such a diagnosis. And if there is a blank, it means there is no such diagnosis in DSM-IV.

Q. And what are the other columns? You got dependence, now does that mean that diagnosis of alcohol dependence can be made but caffeine dependence could not be made?
A. That's exactly right. And then you have abuse. Again, there are different criteria. Intoxication, a fancy name for someone basically becoming drunk, so to speak, for that substance. And then is there evidence of a withdrawal syndrome? Those would be the four different diagnoses that are in this chart.
Q. Can you explain a little bit further what is meant by abuse?
A. Sure. If someone could fulfill criteria for abuse, because of the use of a drug, a substance, there is impairment in their life. And there is usually one of four criteria, it happens at sometime during a 12-month period of time. The different criteria can include, number 1, getting in legal trouble as a consequence of abuse of this drug.
No. 2, participating in some kind of behavior where there is risks as a consequence of the drug. For example, driving while intoxicated from alcohol would be an example.
Number 3, you actually get impairment at work,

in your educational life, at school, because of the effects of this drug or alcohol. You know, if someone -- look at cannabis here, that's marijuana, if someone goes to class high, they're often not going to remember what they learned about. That would be an example.
And then finally, interpersonal relationship problems because of alcohol or because of drugs someone may argue with their spouse or loved ones; a marital discord, problems with their children, etc. So you would need one of those four criteria to fulfill a diagnosis of a abuse problem.
Q. And so is it correct that one can abuse alcohol, abuse cannabis or marijuana, but can't abuse nicotine on the DSM-IV?
A. That's correct. I mean, for example, people don't get arrested from behavior related to smoking cigarettes. They don't have impairment going to school or going to work. They don't have interpersonal relationship problems as it relates to the abuse of smoking a cigarette. So you don't see those kind of problems related to either nicotine by itself or nicotine found in cigarette smoke.
Q. The next column, intoxication, what's meant by

intoxication? You said drunk?

A. Well, that would be kind of a lay term for intoxication. What it means is there is impairment in -- excuse me -- there is impairment in our thinking abilities as it relates to a drug. We are probably most familiar with alcohol, so we will use that as an example. People get a little high, a little euphoric, a very pleasant feeling from drinking. There is impairment in their ability to think, in their ability to make decisions. They may get belligerent. They may get mood lability, their moods go up and down. They may have problem concentrating and focusing.

So as a consequence of these various drugs, where you can see a diagnosis of intoxication, in fact, every single one has that except for nicotine. You can have problems with thinking, focusing, concentrating, making decisions, belligerent, moody behavior, that is the more scientific explanation of intoxication.

Q. Interesting, you noted that every one except nicotine as an X by intoxication. And if we move up to caffeine, that's the only X that caffeine has is under intoxication.

A. Yeah, it sounds funny. You wouldn't expect caffeine to intoxicate a person. If you go to Starbucks and have a large coffee, you're not going to get intoxicated. But if someone ingested enough caffeine,

you know, in 7-11's Hess Express they have these No Doze. If you pop enough of those No Doze, you can get intoxicated. You can get very anxious and agitated. You can have problems focusing and concentrating. You won't sleep. You can become belligerent and angry and anxious.

So although not common, and rarely a problem in people's lives, you can get caffeine intoxication. To be honest, more importantly caffeine is important to psychiatrists in the aspect that it can worsen certain anxiety disorders. So let's say I have a patient that has a panic anxiety attacks. Some of them can be induced if they drink too much caffeine related substances. So part of my treatment will get them to reduce their caffeine.

Q. The final column, withdrawal, what does that refer to?

A. Well, we kind of talked about that. In term of withdrawal, it means if your body is used to a substance and you no longer ingest the substance, is there a physical reaction to no longer having that substance? And where there are X's, there have been documented cases of people having withdrawal from these substances.

Now, the severity or the degree of withdrawal

varies tremendously. But the point is that for all of these with X's, there has been some type of documentation that you can see some type of withdrawal.

Q. Can you give the jury some examples. For example, just starting at the top you got an X under alcohol withdrawal. What is that about?

A. Well, alcohol withdrawal, if I would look at all these drugs, I would say that's the most dangerous, or has the most potential for danger. And I discussed

previously I worked out of various substance abuse hospitals. We almost always admit a person if they have any significant degree of alcoholism to a hospital because the withdrawal that can occur can be life threatening. People have seizures sometimes, grand mall epileptic seizures as a consequence of withdrawing from alcohol.

There is something called DT's, stands for Delirium tremors, which is a very dangerous possibility of withdrawal. 15 percent of people who have this died. Actually died from DT's, 15 percent.

People when they have DT's, they will see spiders and ants crawling all over the walls or on their body. They sweat. Their blood pressure gets very, very high. Their pulse rate gets very high. So it really can be quite dangerous. So we admit them to a hospital,

we put them on medications, tranquilizers, antiseizure meds to reduce the risk of these withdrawals. So it can be quite dangerous.

Another example would be cocaine. Cocaine withdrawal is dangerous more psychiatrically than it is physically. People use cocaine because they will describe a very intense high feeling, especially people that use IV cocaine and smoke crack cocaine.

Well, there is an old saying, "you're always going to pay for the highs with the low." So after a cocaine high, as long as they're not still using cocaine, they often dip into the most severe depression you will ever see in your life. Very accuse, very fast suicidal depression and some people will commit suicide after a big cocaine bing. So again, sometimes we have to admit people to the hospital to monitor their safety. Sometimes we give them some medication to make the depressive reaction less intense.

And then finally --

Q. Let's go to the opioids?

A. And then opioids, again fancy name for narcotics or heroin. Opioids, the withdrawal is not -- it's not necessarily physically dangerous. Although, if you ever saw someone withdrawing, you would think it's dangerous. It's very uncomfortable, very nasty. There

is the most intense craving people will describe. This is why some people will prostitute themselves or they rob or steal for money for heroin. It's an incredible intense craving. When they can't get to it, they have unbelievable abdominal cramping. They will hold their gut and they will throw up. They will have diarrhea, very intense GI symptoms. And they will sweat and their heart rate will go up. It is incredibly uncomfortable.

So we will give them medication in a hospital. Sometimes outpatient, generally in a hospital, to help make the withdrawal less unpleasant. And I really want them in an environment where they cannot get to narcotics, to opioids. So again, not necessarily dangerous physically, but very, very uncomfortable.

Q. Let's go last then to nicotine withdrawal. And can you describe the withdrawal symptoms and comparatively --

A. Sure.

Q. -- discuss it?

A. Again, you can see withdrawal approximately 50

percent, give or take a few percentage points of people will describe it. But it's really different. Nobody is admitted to the hospital. People don't miss work. People don't miss, you know, social activities. It is more of an unpleasant feeling. People get irritable,

3956

sometimes angry, antsy, they may have some difficulty sleeping. They may not focus as well.

Now, again, it's not the kind of inability to focus where you can't function. It's more, you know, I'm a little forgetful. I'm just not as sharp as I normally am. And when people smoke cigarettes they get a reduction in appetite often. So when you stop, you can get an increased appetite. And that's why sometimes people will gain five, ten pounds or so after they stop smoking. You lose that reduction in your appetite. So those are the most common symptoms. Some people have some. Some people have all. But it's mild, it's transient. Tends to go away in a few weeks or so. So there's a difference in not only the number of symptoms, but in how it impacts a person's life.

MR. LYDON: Your Honor, we may want to take a recess. I'm going to be asking him to step down shortly.

THE COURT: Okay. We will take about a ten minute recess.

THE BAILIFF: All rise.

(A recess was taken, after which the following proceedings were had:) 10:10.)

THE COURT: All right. Sheriff, let's bring the jury back, if they are ready.

3957

(The following took place in the presence and hearing of the jury.)

THE BAILIFF: The jury is in the jury box seated, Your Honor.

THE COURT: Thank you, Sheriff.

MR. LYDON: May I proceed, Your Honor?

THE COURT: Mr. Lydon, you may continue.

BY MR. LYDON:

Q. Dr. Kaplan, you told us earlier about your training and experience in pharmacology and psychopharmacology and the effect of drugs on the human body. Can you explain to the jury just what it means to say that a substance has a psychoactive effect?

A. Sure.

Q. All that means is that somehow the chemical or substance gets into the blood system by smoking, by injection, by swallowing a pill. And from there it travels to the brain, and then in the brain there are millions and millions of receptors. So there is a -- it's almost like a key in a lock. The substance binds to a receptor, and then there is a chemical reaction that occurs. Depending on what chemicals get stimulated in what parts of the brain, we will sense -- we will have different types of feelings?

MR. LYDON: All right. Can we look at

3958

Demonstrative 5 again.

BY MR. LYDON:

Q. Those very substances on the left-hand column, are those psychoactive substances?

A. Yes. Every one of those substances have

psychoactive effects, sure.
Q. Including caffeine?
A. Including caffeine.
Q. And are there other examples that you might give us of substances that are psychoactive?
A. Oh, sure. I mean, outside of substances that are found in DSM-IV, there are numerous chemicals that occur that -- in food that have psychoactive effects. Chocolate is a very common example. There are psychoactive effects from chocolate. Sugar, the brain uses sugar as its main source of energy, so there is effects when we consume sugar. If you eat a fatty meal, there is psychoactive effects from the fat in food. That's, you know, often why we have a sense of satisfaction in feeling full. And then outside of actual substances, actual environmental stimuli can change the chemicals that the same substances change. So, for example, if you listen to music you find relaxing or pleasant, certain chemicals are released. In you listen to music that you find more stimulating,

hard rock or something like that, other chemicals can be released. If you are engaged in sexual activity, chemicals are released. So a substance binding to a receptor can affect brain chemistry; and also thoughts, feelings, environmental stimuli can also affect the same chemicals.
Q. Now, did you direct the preparation of a chart or board that we have here in the courtroom to explain how psychoactive substances affect the brain?
A. Yes. It's a picture of the brain and parts of the brain and what we believe they are responsible for.
MR. LYDON: Your Honor, could Dr. Kaplan step down?
THE COURT: Yes.
(The witness leaves the stand.)
BY MR. LYDON:
Q. Dr. Kaplan, is this the exhibit that you asked to be prepared?
A. Yes, it is.
Q. And using that exhibit as an example, can you explain or show the jury how nicotine as a psychoactive substance affects the brain?
A. Sure. Let me give you a real, real brief lesson on parts of the brain here.
The brain stem gives nerve impulses to our

body. We can move our arms and legs and thing likes that. And also very important in having a heart beat and having us breath without actually thinking about how to do that.
The cerebellum area is important for coordination. So if I had a stroke here, I would fall down. I wouldn't be able to keep my balance.
And then we are able to see things in this occipital area.
This midpart of the brain, the limbic area, et cetera, is a real important area in how we feel. So that's the seat of depression, mood differences: Are we happy, are we sad, are we anxious. It's also the seat of what we call in psychiatry "vegetative symptoms": Are we thirsty, are we hungry, are we motivated, are we interested in sexual behaviors, things like that. And

the ability to form new memory.

And then this area is the newest part of the brain to develop, and that is called the frontal lobes. And the frontal lobe is what makes us human beings, makes us more than animals. We can make decisions. So we have these areas of the brain kind of telling the frontal lobe what we would like to do and what we think about doing, and then we have the frontal lobe telling us whether that is legal or moral or ethical or in our

3961

best interest. So the frontal lobe is responsible for organizing our life, planning activities, making decisions, and, again, controlling behavior: I'm not going to hit that person; I'm not going to speed in my car; I'm not going to use that drug. You may want to do things, but the frontal lobe say whether we are going to or not.

All right. So let's get down to nicotine. So, again, smoke a cigarette; it contains nicotine. It gets in the lungs, and then it gets into the blood system, into the brain pretty quick. About ten seconds after you take a puff you will have nicotine in the brain. It binds to receptors called nicotinic receptors, okay, and then there is a chemical reaction. There are nicotine receptors in these areas of the brain. This is not an unusual state. There are numerous types of receptors for a whole bunch of substances. In this case nicotinic receptors. So nicotine binds to a receptor, and you get certain chemicals released.

Now, let me draw on here. I will put a circle here.

Okay. The one chemical that you might have heard about from some of the doctors that a lot of people talk about in regards to nicotine is dopamine.

3962

Think of dopamine as a pleasure chemical. Dopamine is enjoyable. It makes us feel good. So substances or behaviors that are pleasurable often will raise dopamine levels.

Well, there is an area here called the "nucleus accumbens" and the "nigrostriatal area." Those names are not important, but they are where a lot of dopamine nerve cells are packed. And then from there they send messages to other parts of the brain. So the nucleus accumbens -- I will put arrows here -- is going to send messages to the cerebellum and to the body, areas of the brain, parietal lobes; and it's going to tell us, "Wow, this feels good. I like this. This is enjoyable. I feel -- you know, have a nice sense." And in this area I might get kind of more movement of my muscles, and some people develop ticks from too much dopamine. You don't see that from cigarettes, but like amphetamines sometimes produce ticks or jerky movements or ticks of their voice. They will say words out of nowhere. That's the effect of dopamine. So that's dopamine.

Then there is an area kind of almost on top of it but in a little different area. I will put a box for this, the LC, the locus caeruleus. Again, a fancy name. What's important is that's the place where the

3963

norepinephrine nerves are found. Norepinephrine is a

fancy term -- you may be familiar with the term of "adrenaline": My adrenaline is flowing. Okay. Norepinephrine is a scientific term for that.

And norepinephrine is real important in focus, concentration, affecting our mood also. It is not as pleasant as dopamine, but still helps us feel good. That medication I told you about, that Strattera for ADHD, raises norepinephrine. Okay. So when you smoke cigarettes, nicotine binds to the receptors. In addition to increasing dopamine, we increase norepinephrine. And again, it's going to send messages out, projections out that are going to overlap some of these other projections to tell the frontal lobe, "My mood is better. I'm focusing and concentrating better. Maybe I will have a little more muscle tension. I can get ready to run."

And there is another area -- I will put an open circle here -- called the "raphe nucleus," and that is the seat of serotonin. So all these antidepressants you see on TV -- Prozac, Paxil, Zoloft, Celexa -- they raise serotonin. It's a real important chemical in mood regulation to treat depression. And, again, there is going to be projections to other areas of the brain. That's how we know -- and a lot of projections stay in

the mid range to help us sleep better, to have a normal appetite.

And then finally when nicotine binds to receptors, there is also increase in acetylcholine, a real important chemical for focusing. And that more is -- is in numerous -- I will just put an "A" here -- in numerous areas there are acetylcholine projections. Alzheimer's dementia -- people with dementia, they lose brain cells that release acetylcholine. So if you don't have as much acetylcholine, you have problems remembering. So that's why when people smoke, sometimes they are a little sharper, because it raises acetylcholine.

So to make a long story short, nicotine binds to receptors. We can get an increase in certain chemicals. A fancy name for that is neurotransmitters. Dopamine: Pleasure. Norepinephrine: Focus, food regulation. Serotonin: Mood regulation, sleep, appetite regulation. And acetylcholine: Thinking, memory.

So here is the thing, they send messages out. Now, again, what makes us human beings, what makes us more than animals? We have a frontal lobe. Now, the frontal lobe decides what to do with this information. If I felt good and I like this behavior, then I have to

decide based on not just a feeling, but based on my education, my life experience, what I believe is right and wrong, healthy and unhealthy, and whether I'm going to continue that. This frontal lobe now sends messages back and makes decisions; and then it sends messages back to the midbrain, to the body, to the coordination area and tells it whether or not we are going to continue that behavior.

So let's go back to cigarettes containing nicotine. It feels good. Certainly, I mean, that's part of why people smoke. It's pleasurable. Based on life experience, access to information, what we consider

healthy or not healthy, now we have the choice of saying whether or not we are going to continue that behavior. Okay. Again, control, planning, organization.

Now, we think dopamine is related to drug craving and this pleasurable feeling. Nicotine will increase dopamine, that's for sure. Other drugs increase it too, and they increase it to a much more significant effect. So if I had like a list and I looked at nicotine, smoke a cigarette, about a onefold increase. We double the amount of dopamine, essentially. Alcohol, twofold. Okay. We are going to have an increase in dopamine about twice that of that smoking a cigarette. Cocaine, three to fourfold

increase. Amphetamine -- of all the drugs, actually the biggest increase in dopamine is uppers, amphetamines. Ritalin for ADHD and Dexedrine raise it tenfold. And that's why from those kind of drugs, sometimes the impulse or desire, the pleasure feeling from them can be more intense than drugs that have a less intense effect on dopamine.

Behaviors unrelated to ingesting a substance they gave perhaps a chocolate-flavored beverage to increase dopamine a 0.7374 increase. So it increased it, although not as much as cigarettes or other drugs. Sexual activity increases it about 0.5 percent.

So, again, behaviors and drugs raise dopamine, sends message. The frontal lobe then decides, "Am I going to continue this? Am I going to adapt my behavior?" And just to kind of complete things, what if we didn't have a frontal lobe? What if we were a rat? And what if we have dementia and the nerve cells die here? My grandmother had dementia. She died from Alzheimer's. She broke the nose of a nurse in a nursing home. If you lose control -- you have impulses: "I want to hit that person. I want to kiss that person. I want to speed in my car. I want to use a drugs." If you don't have this, you are going to do those things because you don't have an area in your brain to say

"Don't do that. That's not unhealthy." Okay? So Alzheimer's patients lose this; and Therefore, they can't control their impulses.

So that's why when we talk about a chemical, an inability to stop doing things and things like that, as long as you have an intact frontal lobe, it's not impaired by an illness, people are able to decide how and when they are going to control these kind of behaviors. Again, I'm not saying it's easy. I'm saying they are able to do it with those kind of choices.

Q. Before we leave this exhibit, in talking about that frontal lobe, is there a form of therapy that specifically -- that psychiatrists use that specifically deals with the frontal lobe, working with the frontal lobe?

A. Sure. The most studied therapy -- psychotherapy for the treatment of psychiatric disorders is called "cognitive behavioral therapy." And quite simply, we are going to use this part of the brain without taking any drugs or medications. We are going to use this part of the brain to affect chemistry in this part. So, again, think of depression as a lack of serotonin, norepinephrine, and dopamine. Okay.

Antidepressants raise those.
Forget medications for a second. We are going
3968
to teach people -- when people are depressed, the symptoms here -- lack of sleep, lack of appetite, sad mood, things like that, lack of libido, sexual interest -- so we have lack of chemicals here -- we are going to use the frontal lobes to teach them how to think in more positive ways. I don't say "The glass is half empty or half full" or things like that. For the depressed people, it's always "The glass is half empty." We are going to teach them to think in positive ways: "I'm not unhappy. I'm not stupid." Some people -- depressed people have those thoughts. To teach them to change their thoughts, not to lie to themselves and think more realistically. And just by doing that artistically, we are going to raise chemicals in the midbrain to help treat depression.
So, yes, the frontal lobe through different types of therapy can actually affect chemistry in the midpart of the brain.
Q. Before you resume the stand, you see the -- ask you this question because when you are up there, you won't be able to see the chart.
All the different colors here, a couple of weeks ago Dr. Jacobs was here and showed something called a PET scan that had a number of colors. Are you familiar with PET scans, first of all?
3969
A. Yes.
Q. What are they?
A. PET scan stands for "positive emission tomography." And as opposed to like a CAT scan, which is an x-ray of the brain, of its structure, a PET scan actually looks at metabolism, the actual workings of the brain at a certain time, taking a picture of it.
Q. The PET scan is the head from the top down; correct?
A. That's one of the angles you can take a PET scan picture, yes.
Q. And they show different colors. The colors here have nothing to do with the colors in that exhibit --
A. No.
Q. -- right?
A. This is just to help people visualize the areas. The PET scan, basically the more activity of something it's going to heat up red, orange. The less activity, dark blues, blacks, grays, things like that.
Q. Okay. Doctor, if you can resume the stand, please.
(The witness returned to the stand.)
When Dr. Jacobs testified a few weeks ago, he mentioned something called "monoamine oxidase" or
3970
"MAOB." Are you familiar with what that is?
A. Yes.
Q. And he talked about it in terms of there being some theory about cigarette smoke that affects monoamine oxidase. Can you explain, first of all, what monoamine oxidase is to the jury and what you know about this.
A. Sure. Monoamine oxidase is an enzyme. You all have it in your brain. I have it. Everyone here

has it. It's nothing fancy. It's a natural enzyme. And remember these chemicals that I showed you: Serotonin, norepinephrine, dopamine. The body has ways of making more of these chemicals, and the body recycles, basically. So it chews up these chemicals down to building blocks so it can make more. Monoamine oxidase is the recycler. It chews up these chemicals into building blocks so we can make more. So if you inhibit monoamine oxidase, okay, monoamine oxidase inhibitors -- if you inhibit it, then you increase the amount of chemicals because you are not breaking it down. So if you look at the theory that depression is caused by a lack of these chemicals and you inhibit the enzyme, you treat depression.

So some of the oldest antidepressants available that came out in 1950s are MAO inhibitors.

Q. And how does that appear on a PET scan, monoamine oxidase?

A. Well, first of all, when you take a PET scan, you are tagging chemicals to look at a certain reaction. Actually, most PET scans are used to look at the brain utilizing glucose; so they tag glucose with a radioisotope, and it shows up on a PET scan. In this case they were tagging only for the enzyme monoamine oxidase. And what it showed was some evidence -- and this is not new. This has been around for 20 years or so -- that something in cigarette smoke may cause some mild inhibition of this enzyme. And that being said, just because it is seen on PET scan, clinically I think it's irrelevant. I don't think inhibiting monoamine oxidase from cigarette smoke in human beings has any clinical significance at all.

Q. Well, can you explain -- give an example, perhaps?

A. Sure. The best example is to go back to that antidepressant: Nardil, Parnate. These are MAO inhibitors, serious antidepressant medications. When you inhibit this enzyme in the brain, you inhibit it in your gut.

And foods that we eat all the time -- if we drink a beer, if we eat fermented foods, if we eat cheese, they contain a chemical called "tyramine."

Okay. MAO -- the enzyme in your GI tract stops you from absorbing tyramine. So if you inhibit this enzyme through a medication, you absorb tyramine; and you could die. Tyramine is what we call "pressor agent." It raises blood pressure.

So people on these medications have to be on a special restricted diet. They can't eat cheese. I have patients who go to Dominos, and they ask for Pizza without cheese. They can't even eat cheese at all. They can't have fermented foods. They can't have beer because it contains tyramine.

If the inhibition of MAO from cigarette smoking had any clinical significance, literally hundreds of millions of people would stroke out when they smoke a cigarette and drank beer, ate some cheese, ate fermented foods. So what this means is that if something in cigarette smoke has some inhibition of MAO, it is very, very weak because you do not see that reaction when people

smoke and eat cheese and do these other things.
Again, could you see it on a PET scan? Sure. PET scans are highly sensitive. Does it mean anything in real life? No, I don't think it has any clinical significance at all.
Q. Thank you, Doctor.

3973

Doctor, again, you referred to the fact that you personally conducted a psychiatric evaluation of Mr. Eastman in February of this year; is that right?
A. Yes, I did.
Q. And what did you do, again, to prepare for the evaluation?
A. I spent a lot of time. There is a lot of information in this case Mr. Eastman had three depositions. Numerous ex-wives and family members and friends were deposed. His doctors, some of them were deposed. There is a lot of medical records in this case. So I reviewed all that information, and then, again, I saw him for an examination.
Q. And describe what happened at the examination itself. What happened there? Just a standard examination, first of all?
A. Well, not standard.
Q. Okay.
A. When I see a patient in my office, we have what we call doctor-patient relationships. In other words, I can't share what I heard from this person. Everything is confidential unless they ask me to. This is different. In a psychiatric examination that's related to medical and legal issues, it's not

3974

confidential. So Mr. Eastman, we had a nice conversation, but he is not -- he is not my patient. I didn't provide therapy to him or treatment. I gathered information, and then I shared the information in a report to the attorneys for the defense and the plaintiff, Mr. Eastman. So it's different because it's not a -- it's not confidential evaluation. It's more of an information-gathering evaluation.
Q. And what did you do? What was it about, just general structure?
A. I asked him many, many questions. The actual examination took approximately five hours. And there is a section of it where he was to complete a psychological test called the MMPI. And it was a long day, and he was a bit tired. So I actually had my office manager meet with him a few days later, and that is when he completed the psychological testing component of it.
Q. That psychological testing component, can you explain -- is that something that requires someone to ask questions, or how is that actually completed, that --
A. The MMPI, Minnesota Multiphasic Personality Inventory, is an objective psychiatric test -- psychologic test, really. And it looks at personality characteristics in people who have symptoms of illnesses

3975

and thing like that. It is a long test. It's over 500 true/false questions, and the clinician is not involved in the test at all. So the person would sit down and bubble in either "yes" or "no," "true" or "false" for a

variety of, you know, short questions that --
Q. So that's a written test?
A. It is a written test, yes.
Q. Okay. Now, after you completed this examination, did you prepare a report?
A. Yes, I did.
Q. And after you prepared your report, did you prepare for this jury a -- an exhibit which summarizes your opinions to a reasonable degree of probability to Mr. Eastman?
A. Yes, I did.
MR. LYDON: Can we look at Slide No. 6, please.
BY MR. LYDON:
Q. Slide No. 6 that's before the Court and jury, Dr. Kaplan, are those the opinions that you formed regarding Mr. Eastman?
A. Yes, they are.
Q. Would you explain to the jury what the basis is for the first of those opinions: "no cognitive impairment. Mr. Eastman is an intelligent person and

emotionally stable." What's the basis on which you formed that opinion?
A. Sure. Well, the basis is based on all the information I reviewed, and I'm not going to bore you with continuing to go over that again and again. But just one last time, depositions, medical records, my examination, and court testimony, based on that and the examination, I asked a series of questions to evaluate cognitive functioning, thinking abilities. And I found no evidence that there was a history of impairment, problems with thinking, or current evidence. I found Mr. Eastman to be a very intelligent man. Lots of people who know him, who knew him, describe him as intelligent and emotionally stable. In other words, when I did the evaluation in February of this year, I found no evidence of a psychiatric disorder. So in terms of an emotional condition, he is stable.
Q. You mentioned your own observations and those of numerous other people. Did you prepare an exhibit summarizing the characteristics of Mr. Eastman that you gleaned from your observation as well as what you read about others saying?
A. Yes, I did.
MR. LYDON: Could we look at No. 7, please.
BY MR. LYDON:

Q. And just explain what's set out there.
A. Sure. If you look at the literally thousands of pages of depositions of people who really knew Mr. Eastman well and Mr. Eastman's deposition and myself meeting him, there is a lot of similarities in how people describe him. He has a lot of very positive characteristics here. So, you know, we all have a personality and our aspects of our personality, and these are the things that people describe, and I have also seen that in my evaluation.
Number one, clearly he is a very intelligent man. You can't attain the degree of success he did directing and producing and being a radio and TV announcer and things like that without being an intelligent person. So, you know, again, intelligence,

that's certainly above average.
He is decisive. He is able to and has made decisions in his life when he wanted to.
He is strong-willed. He is somewhat opinionated. And when he has a strong opinion about something, he kind of sticks to his guns, so to speak.
He is goal-oriented when he has a goal, an example in terms of some of his occupational goals in the past. He will come up with a game plan and work towards those goals.

He is curious. He is inquisitive. He was an interviewer and very talented at it and would meet with people and try to understand what they were about and what they could offer the listening public.
Resourceful. He knows how to gather information when he is coming up with a project, libraries and books and magazines and talking to experts to achieve a finished product, so to speak. He is very creative. He is an artist. He is a writer. He is a producer. He is a director. And he certainly created some interesting projects: Movies, short stories, things like that.
And he is an independent thinker. Many people described him as that. It kind of goes along with strong-willed. He is able to think for himself. So even if he has ideas that are not consistent -- excuse me -- that are not consistent with the rest of the population or the majority of people, he is able to think outside the box. He is able to think about things in a way that he thinks is accurate or correct.
So, you know, what do all these have in common? They are positive characteristics. They are generally healthy characteristics. And how these relate to this case is if you want to change behavior, if you have a goal in mind, you need these types of

characteristics, or these types of characteristics are beneficial in being successful. If you have the goal of stopping smoking cigarettes or changing other behaviors, intelligence helps. Decisiveness, strong-willed, goal-oriented, curiosity, resourcefulness, creative, these are all helpful personality characteristics in attaining that goal.
MR. LYDON: Go back to slide 6, I believe it is.
BY MR. LYDON:
Q. And so we just covered the first of your opinions. The second opinion Mr. Eastman fulfilled DSM-IV criteria for nicotine dependence until 1995. Can you explain the basis for that opinion?
A. Sure. There are, as we discussed previously, criteria in DSM-IV for nicotine dependence. You have to fulfill clinical significance. In other words, the use of this substance has to produce some type of distress or disability. And when I evaluated this case, and looked at all the information, you know, I felt that he probably fulfilled the criteria in 1982, I believe it was, when he had a quit attempt using Smoke Enders. That was the first time that this reasonable information suggesting, you know, some distress associated with this. And then as, you know --

Q. Stop just a minute. Distress associated with what?

A. That he had tried to stop. And, again, there is varying information regarding that quit attempt. But that he found it to be of some difficulty. He described a few withdrawal symptoms. So to give him the benefit of the doubt, he may have had some clinical significance there that would have fulfilled this criteria. And then he stopped smoking and hasn't smoked since 1995. And according to the DSM-IV rules once you successfully stopped and you are compliant and you are no longer using that substance, then you no longer fulfill the criteria.

Q. And so by way of explanation, to be diagnosed as nicotine dependent, does that mean you can't quit or obviously it doesn't?

A. No, not at all. It's just a way of describing a phenomenon, again, there are certain criteria. But by no means people that fulfill criteria absolutely are able to change their behavior to stop if they want to. And in terms of severity, I found Mr. Eastman's DSM-IV nicotine dependence diagnosis to be very much in the mild range.

Q. No. 4 -- excuse me, No. 3, didn't get past that. Mr. Eastman knew of the health risks of smoking

dating back to the 1950's. What do you base that opinion on?

A. Well, again, I'm not going to bore the jury, but all the sources of information that I looked at, including my examination, showed a lot of evidence. Again, very intelligent man, a radio TV announcer, had a lot of access to information. If we go back to the 1950's and actually perhaps it could even be the late 40's when he was in college, he admitted to talking to people and having some knowledge that smoking was -- I think the word he used, inadvisable.

In addition to that, he acknowledged reading some I believe newspaper articles about some of the health risks associated with smoking.

Then we move into the 60's and that's where his knowledge base increases a lot, Surgeon General's report comes out, the warnings on cigarette packages came out. He acknowledged knowing about that, understanding it, believing that some of that data was accurate.

He becomes a radio announcer and a TV broadcaster. He is actually the person that teaches us what's new in the world. So he had access to whatever types of information was available at that time in the media about the health -- potential health warnings and

risks associated with cigarette smoking. He described himself as an avid reader; magazines and books and newspapers, had access to information in there. As we know, he developed testicular cancer early, early 60's.

During that time kind of looked at his life, examined his life to make decisions about where he wanted to go from there, looked at the issues of am I going to continue to smoke? Am I going to continue to drink alcohol? You know, what are my behaviors going to be like? And after examining, he continued to smoke. But the point is, thought about his life decisions, had

some knowledge about the risk of certain cancers associated -- that may be associated with cigarette smoking. Friends, people that he interviewed gave him access, a lot of information in the 60's.

Then in the 70's again he continues to be a broadcaster, a television personality, has this information, reading, watching TV, etc. And then as we know, some of the warnings on cigarette packages were more specific as to some of the health consequences.

And then finally in the 80's, clinicians, his treating clinicians start to warn him. Dentist talks to him about the warnings of possible dangers of smoking cigarettes. Dr. Tatum, I believe his name is. A urologist, Dr. Stein warns him that he

is probably having some impotence problems as a consequence, at least partially to cigarette smoking, warns him to stop. A nurse, when he was admitted to Tampa General Hospital, warns him about some dangers regarding smoking and the need to stop. So he has more information. Interviews, clinicians, I believe he saw a therapist who discussed some issues regarding smoking.

So, again, more and more information. And then it continues on into the 90's. So the point is all the way back to the 50's, maybe even the late 40's when he was in college, intelligent man, certainly knowledgeable regarding information that was out there regarding potential risk of smoking and, again, tried to support that by giving you information regarding where he said that he heard about these things.

Q. All right. Your fourth opinion, that Mr. Eastman always had the ability to quit, and did successfully quit in 1995. And that he has never relapsed. The basis for that opinion?

A. Well, the basis is, again, all the information I reviewed, my evaluation, my clinical experience treating people who tried to stop smoking. I didn't find any evidence that he had any types of impairments

that would have stopped him from being able to successfully quit at any time during his smoking career if he wanted to. He did stop in 1995. He has never relapsed. So, you know, again, if -- you got to be motivated. You got to be committed. But if he were, I believe he had the personality characteristics. I believe he had access to information, he knew about ways to stop and could have stopped any time before '95.

Q. Did you select a portion of the transcript of Mr. Eastman's testimony -- excuse me -- could we put that back up for a minute -- that demonstrated your findings in No. 4 and in opinion No. 2 as well?

A. Yes, sir.

MR. LYDON: Could we go to 3055, I believe it is

BY MR. LYDON:

Q. Is this the excerpt that you picked out and could you explain its significance to you?

A. Yes, this is actually from this trial. "Have you smoked a cigarette since you went in the hospital in 1995?

No.

Do you still have cravings for cigarettes?
Yes, now and then".
Well, the significance is No. 1 he did

3985

successfully stop in '95 and has not relapsed. And No. 2, he still has cravings. He still has a desire and an interest at time to smoke, but he has made the decision "I'm not going to do that". So even though he has had cravings, he has been able to not relapse.

Q. Now, from your review of the records and testimony in this case, did you learn of a -- concerning this same point of your opinions, did you learn of Mr. Eastman's experience with an organization called Smoke Enders?

A. Yes, I did.

Q. And did you select portions of Mr. Eastman's testimony -- I believe this was deposition testimony -- in which you thought -- well, what you thought was important to explain to the jury in -- with respect to the Smoke Enders experience?

A. Yes, there was information in his deposition that I think was very relevant in terms of his possible quit attempt using the Smoke Enders system.

Q. And was Smoke Enders the 1982 reference you had made earlier?

A. Correct.

MR. LYDON: Okay. Could we have those references, please. And I think we are talking about page 365 first.

3986

BY MR. LYDON

Q. Is this the portion that you selected from page 365?

A. Yes. It kind of leads up into that quit attempt. "How long have you known that, that some people have great difficulty in quitting smoking?

I have always known it.

"QUESTION: When did you first decide that you were having great difficulty in quitting smoking?

I never tried to quit smoking. I was hired to quit smoking once by the Smoke Enders".

MR. LYDON: Could we go to the next page 366, please, and it continues on.

A. And --

"QUESTION: "And I take it that the first time you ever attempted to quit smoking.

"ANSWER: Yes. Yes, it was.

"QUESTION: And the reason you did it then was as part of a promotional --

"ANSWER: They paid me a fee.

"QUESTION: How much did they pay you?

Oh, I don't know, hundreds of dollars.

MR. LYDON: Could we go to 370, please.

A. "I had to surrender and give them back their money. Quit. But how long do you --

3987

"ANSWER: I tried for about a week and I lied for another week. I lied the whole time, as a matter of fact, so I quit out of -- a choice I badly made all my life between hypocrisy and money.

Okay. Who was the head of Smoke Enders? Do you remember?

No.

Who approached you about it?
A salesman, whose name I don't know."
MR. LYDON: And 373.
A. "Question: "And would you tell your listening audience that now you are taking -- Hey, I'm trying something, Smoke Enders.
"ANSWER: Yes.
"QUESTION: It's really working, it's great stuff?
"ANSWER: Yes.
"QUESTION: But you weren't really telling them the truth?
"ANSWER: No.
"QUESTION: Would you be smoking at the same time you're using this Smoke Enders?
"ANSWER: If it were -- if the opportunity were there, yes. But the problem was the people outside looking in the window laughing at me.

3988

"QUESTION: Because they could see you smoking and talking?
"ANSWER: I was a fraud. I was a fraud. I knew it. They knew it. And I said this is not -- this can't be. I quit".
MR. LYDON: And page 373, I believe it is.
A. "Were you actually committed to quitting smoking using Smoke Enders at that point?
"ANSWER: No, I can't say that I was.
"QUESTION: Did you ever attempt to quit smoking again prior to your diagnosis with COPD.
"ANSWER: No."
Q. Okay. Could you comment on that Smoke Enders experience and how you observed this as it relates to Mr. Eastman and your opinions?
A. Sure. I think there is relevance in several places here. No. 1, he didn't search out people from Smoke Enders to stop smoking. They came to him with a promotional opportunity to see if he would talk about their product and try to stop smoking. That talks of interest and commitment and things like that.
No. 2, according to his deposition, he smoked while he was using Smoke Enders. Now in my IME he did describe that he stopped for 24 hours and then for 26 hours. So there is varying information in terms of

3989

what's in the deposition and what he described when I met him for an examination. Nonetheless, he described the action of Smoke Enders as ingesting a liquid and that was it. Smoke Enders was a much more complete program. Smoke Enders --
Q. But how is it important to your opinion? What were you saying about they sought him out, he didn't seek them out?
A. Well, why that's important is -- again, it goes to the issue of how interested, how motivated, how committed is a person in stopping. Like I said before; my own experience in treating people, if they're not interested, they are often not successful. He didn't search out help. Someone with help came to him, and, again, it was very much a promotional financial type of situation. So I don't believe that he was very committed to utilizing this program.
Q. Did you also review I think you mentioned a

Dr. Stein?
A. Yes, I did.
Q. And was that testimony significant in forming your opinion -- opinions?
A. Yes, there was information in the deposition from Dr. Stein that I felt was significant.
Q. Why?

A. Well, because Dr. Stein provided him with information regarding some of the potential health risks of cigarette smoking as it related to a problem with impotence. So, again, it provided knowledge. In addition, based on the deposition it really did not appear in regards to Dr. Stein's recollection that Mr. Eastman was very motivated to stop smoking. Smoking -- he was very stressed about his occupation and smoking was related to working and stress and stress relief, and he wanted to search for other ways of treating his problem outside of stopping smoking.
Q. Have you in fact selected portions of Mr. Eastman's trial testimony with respect to his 1987 visit to Dr. Stein?
A. Yes, I have.
Q. And was -- how, again, did this relate to the opinions in your case?
A. Well, it's just another example that the evidence strongly suggests that until he stopped in 1995, he really wasn't very motivated and committed to stop.
MR. LYDON: Can we look at 3082, please, lines -- I think 18 to 25.
A. "Question: "Do you remember in 1987 saying that the thoughts didn't cross your mind, you weren't

interested in quitting smoking?
Probably said that, too.
"QUESTION: That it wasn't your attitude, right, to quit?
"ANSWER: I probably said that, too.
"QUESTION: Is that you weren't in the mood to quit?
"ANSWER: Said that, too. A man with a mouth like mine is all over the block."
Q. Now, did Mr. Eastman -- you can take that down. Oh, wait. Before we -- and what does that tell you with respect to the opinions that you formed in this case, the total?
A. Well, you know, again, this is not the words of a person who is committed to changing their behavior. Not in the mood, not committed. Again, you have to have an interest. You have to be committed to stop smoking. When you are, then you can be successful. Until '95 I just don't find evidence that he was.
Q. Did Mr. Eastman from what you can determine have any withdrawal symptoms during his successful effort to stop smoking in 1995?
A. No. He was admitted to the hospital with a respiratory problem, and according to him and according to the medical records, there is no documentation that

he had any withdrawal symptoms when he stopped smoking.
Q. Well, what about the fact that he was very ill at the time?

A. Well, he was ill, and certainly I'm sure he had other things on his mind than not -- than smoking cigarettes. But people who are admitted to medical hospitals for various reasons who abuse other substances, they still go through withdrawal. If someone is a heroin addict and they're admitted to the hospital because they have a bacterial infection from injecting themselves with dirty needles, you still have to treat the withdrawal, even if they are sick as dogs from the sepsis, the bacterial infection, they still go through withdrawal.

People who are alcoholics who are admitted for a heart attack, you still have to treat them for possible DT's and seizures. They still can go through withdrawals. So the fact that he is admitted with a respiratory problem negating the fact that he wouldn't have any withdrawal symptoms, you do see that with other drugs of abuse.

Q. Did you find anything in any of the medical records or anywhere that described any symptoms of withdrawal for Mr. Eastman?

A. I didn't find that and I also didn't find

evidence they were using significant amounts of medications that would significantly reduce withdrawal symptoms.

Q. Now, let's go to slide 6 again and your last opinion, I think it is, the 5th opinion that Mr. Eastman fulfilled DSM-IV criteria for alcohol dependence. His alcohol use, however, did not impair Mr. Eastman's ability to quit smoking when he was not intoxicated." Explain what that opinion is and how it's relevant overall?

A. Well, during different periods of times of Mr. Eastman's life, again, based on people that lived with him and physician records and Mr. Eastman's testimony, he drank too much, and he admitted to that, and he was able to notice that and also to work on changing his behavior. He tried to reduce it. He went to see a psychiatrist for some treatment to stop drinking. So there is basically evidence that at points of his life, especially when occupational stress was greater, he abused and would have fulfilled the criteria for alcohol dependence, and that he himself was able to modify how much he drank and actually go for some treatment.

Now, remember we talked about those frontal lobes helping us make decisions? If you impair the

frontal lobes by intoxication, they may not work so well. So you may be more likely to act out on your mid brain impulses. So when he was drunk, intoxicated from alcohol, during those times, it might have been more difficult for him to decide to quit. But at all other times when he was not intoxicated, he had the thinking, the frontal lobe capabilities of making a decision to quit and being successful.

Q. And how did he actually use that frontal lobe with respect to the alcohol dependence?

A. Well, No. 1, he himself just made the decision to either reduce or stop at times.

Number 2, he went for professional help. He saw Dr. Afield, Walter Afield who is a psychiatrist in

town. And Dr. Afield put him on Antabuse, which is a medication that makes people really sick if they drink while they have the Antabuse in their system. So he was able to research and to go for some help and I would say using the word modify his drinking behavior.

Q. Did you find from the testimony in the depositions anything that you think is relevant to this last opinion about his -- the way in which he examined his life or made choices?

A. Sure. There is information in there that I think is, you know, similar -- not just to alcohol, but

also to smoking behavior and basically life choices.

Q. And did you select those as well?

A. Yes, I did.

MR. LYDON: Could we look at 270, please, line 1.

A. "Question: "I think what you're saying to me is -- with this last statement is that sometime in connection with your orchiectomy" -- that that's when he had his testicle removed for cancer -- "you began to ponder what you'd been hearing and considering in light of your own mortality that you now had brought to the fore as a result of your cancer diagnosis?

"ANSWER: Right.

"QUESTION: That perhaps you should stop and take stock of what you'd been refuting up to that point or denying up to that point.

"ANSWER: No. Specifically, that there -- was there any life choice or habit or substance abuse or personality trait or other that I was doing that I proposed to myself not to do here after. And I didn't include tobacco in something that I wished not to do or could not do or would not do. I just said, quote I'm going to smoke and I'm going on smoking, and I'm going to take a drink when I want one and I'm going to continue my profession and I'm

going to try to have a positive feeling about life, and I'm going to beat this thing."

Q. And, doctor, in your opinion was there ever a time prior to 1995 that Mr. Eastman was incapable of quitting smoking?

A. No, I believe during his entire smoking history Mr. Eastman was fully capable if he was motivated, if he was committed to successfully stop smoking.

Q. Going back to an exhibit that we saw earlier about why people generally smoked, why did Mr. Eastman smoke in your opinion?

MR. LYDON: Can we look at No. 8.

A. Well, No. 1, nicotine. I do think he got some of the positive sensations from nicotine, so I think that's one of the reasons.

Taste. He didn't really describe that in his depositions or in my evaluation, so I would say taste really not an issue.

Feel. Certainly he described enjoying the tactile, the feel sensation of smoking.

Relaxation and stress relief. There is mixed information here. When asked "did smoking relax you?" He generally said, no. But he certainly said "I smoked more when I was in a stressful situation". That's

actually also in various physician's records. So I would say it did provide some stress relief, although he doesn't recall an actual feeling of relaxation when he smokes.

And finally, social interaction I feel is significant. He described that in college enjoying taking breaks with people, socializing, smoking, discussing things during his life. He is a very social man. So I felt that was one of the benefits he received from smoking.

Q. And then finally, doctor, in your opinion, why didn't John Eastman quit smoking prior to 1995?

A. I think he enjoyed smoking. I don't think before '95 he ever truly was committed and motivated to stop smoking.

MR. LYDON: May I have a moment, Your Honor?

THE COURT: You may.

MR. LYDON: I have no other questions, Your Honor.

THE COURT: All right. Mr. Acosta.

MR. ACOSTA: Thank you, Your Honor

CROSS-EXAMINATION

BY MR. ACOSTA

Q. This looks like a lot, but I'm not going to ask you all these questions.

As you have indicated, we have met before.

A. Yes, we have.

Q. And I'm not going to ask you all the same questions that I asked you a long time ago. But I want to go back over a few things that you testified about with respect to Mr. Eastman and what you have done in the case. First of all, there is a difference between a clinical diagnosis and a -- a forensic diagnosis; correct?

A. There is no difference in the diagnosis, but there certainly is a difference in regards to treating a patient, which we generally consider clinical, and forensic, which we -- involves some type of legal situation.

Q. Well, this book here, this DSM-IV-TR?

A. Right.

Q. It indicates that the book was designed for clinical diagnosis, educational and research settings; correct?

A. That is true.

Q. And then it gives a caution to anyone who uses it for forensic purposes; correct?

A. That's true.

Q. Now, what you have done is have reviewed really thousands of pages of deposition, Mr. Eastman's

deposition was over 600 pages long, wasn't it?

A. I don't recall the exact amount, but it was quite long, yes.

Q. Lots of information in there, and then of course we have a trial. You haven't reviewed all of the trial testimony, have you?

A. No. I have reviewed the testimony -- excuse me -- on Mr. Eastman. I reviewed the trial testimony on Dr. Groff, and Dr -- I'm not recalling your addiction expert's name.

Q. Jacobs?
A. Dr. Jacobs, yes.
Q. He is the one that drew a brain that's over there. Did you see that drawing?
A. I didn't see the drawing, but I read the transcript, so I understand that he made a drawing, yes.
Q. Now, the history that you took of Mr. Eastman, you -- you talked to him about a lot of things. And then at the very end of your interview with him after two or three hours, you started to ask him about smoking. Do you remember that?
A. Yes. I asked him a lot of different questions in regards to issues that are standard in a psychiatric examination. And certainly a focus of this when it was time of the exam was to ask many questions regarding his

smoking history.
Q. And as -- one of the things he told you is that when he tried to quit smoking his anxiety raced and went sky high. Do you remember him telling you that?
A. Yes, I believe when he described the Smoke Enders attempt -- again, what he told me was different than what was in the deposition, but what he said was he did recall actually stopping smoking for 24 hours and then 26 hours and he did describe some withdrawal symptoms with those attempts.
Q. Well, he told you that he had tried cold turkey several times, didn't he?
A. Yes, he did, but they were attempts that were less than 24 hours, and when you look at the issue of a quit attempt, if you go by Surgeon General's criteria, a quit attempt is considered a quit attempt when it's 24 hours or greater. So the actual first possible quit attempt I believe is in 1982 if he actually did stop for 24 and/or 26 hours.
Q. The DSM-IV doesn't say that, though, does it?
A. I believe the DSM-IV does not talk about a duration of time. That's from the '88 Surgeon General's report on tobacco and nicotine related issues.
Q. In any event he told you that he had tried cold turkey several times and tried a number of times

after that in the 70's to try to quit smoking; correct?
A. Correct, again, for less than 24 hours.
Q. Okay. Because he would need a cigarette after a few hours?
A. Well, he described some possible withdrawal symptoms that he certainly had a desire to smoke cigarettes after --
Q. It wasn't in that context that he said his anxiety raced and went sky high and that he was irritable and got more anxious when he didn't have a cigarette?
A. He did describe that, yes.
Q. And he -- he learned that when he didn't have nicotine that it increased his nervousness and irritability to the point where he said it was impossible for him not to smoke. Did he tell you that?
A. I don't recall if that was the exact words he used. He may have. I don't necessarily recall if impossible was the words that he used.
Q. Well, I have it on video. Can we show that and see if that refreshes your recollection, or do you

want --
A. Again, he may have said that. I don't recall if those were the exact words. We talked for five hours. I don't recall every word that he said.

4002

Q. Okay. He told you one of the reasons why he switched to -- or why he continued to smoke Benson and Hedges was because it kept his anxiety away. Do you remember him saying that?
A. Well, I don't recall, again, him saying those exact words, but certainly when he did smoke cigarettes, he was less anxious.
Q. And he eventually got up to four packs a day; is that right? That's 80 cigarettes a day.
A. Towards the very end of his smoking there is some evidence that at times he smoked up to four packs a day. During the vast majority of his smoking history he appeared to smoke between one and two packs a day.
Q. Oh, really?
A. Yes.
Q. He went -- he told you that he went to three packs a day when he moved to Tampa. Do you remember that?
A. Yes, he did say that and also if you look at medical records and his actual trial testimony here, most of the information is more consistent with smoking approximately two packs or less during most of the time he was in Tampa.
In addition, there is some documentation from a Dr. Groff that documents that sometime during the

4003

80's, at least for a period of time, he was able to reduce his cigarettes down to approximately 15 cigarettes a day. So there is actually more information supporting one to two packs a day during most of his smoking history versus three to four packs a day.
Q. All right. But in any event, he told you three packs when he moved to Tampa?
A. He -- I believe he did tell me that at some time when he was in Tampa. I don't necessarily remember if it was when he moved to Tampa.
Q. Now, you know that he saw Dr. Groff in 1980?
A. I believe so, yes.
Q. And you know that Mr. Eastman has mentioned both to you and in his deposition and at trial he has difficulty with dates?
A. I -- I believe I recall that he may have said that in depositions. I recall him saying more that he had difficulty with math, and that's been a chronic problem for him.
Q. Okay. Well, in any event, are you aware now that the Smoke Ender situation was sometime around 1986 or so?
A. If he said that in the trial testimony, I don't recall. The year I recall was more the early 80's, '82, but he could have said that.

4004

Q. Okay. You know that in 1987 when he saw Dr. Stein before there was ever any lawsuit or anything like that, he told Dr. Stein that he couldn't quit; right?
A. I believe -- I don't know if those were the exact words, but it was something similar to that. And

my also understanding was that he was very stressed with his occupation and that smoking was kind of part of him and that he wouldn't be quitting and he was looking for other ways to treat his impotence unrelated to stopping smoking.

Q. But his deposition does in fact indicate that he said that he told Dr. Stein that he couldn't quit?

A. That may be in the deposition. I don't recall specifically.

Q. You -- I have it here. Do you dispute it?

A. No, I didn't say I dispute it. I said that I don't recall specifically. But couldn't and truly being able to, as I alluded to previously, are two different things. I don't believe that he was motivated or committed to truly making a quit attempt at that time. And I think the evidence supports that.

Q. Okay. Now, sometimes when people try to do something over and over and over again and they are unsuccessful at it, can that make them feel guilty about

it?

A. That could happen, sure.

Q. Can it make them feel tormented over the fact that they have tried and tried to do something and realized they can't do it?

A. Well, I wouldn't necessarily use the word tormented. It also depends on what the quit attempt was. If you look at smoking as an example, if you try cold turkey and you don't go for professional help, you don't ask people for help, and you don't take supplements and you don't go for therapy, and you stop after a few hours and you start smoking, that's different than actually going for treatment and participating and really making a significant effort. So the feeling you would get from being unsuccessful would often be different if you were really, really trying versus if you just say, well, you know, I will give it a mild try. I think there is a big difference in my experience working with people.

Q. Now, isn't it true that the -- you talked about -- let me just cover a couple things here -- a diagnosis of substance dependence cannot be applied to caffeine; correct?

A. True. The only diagnosis for caffeine would be intoxication.

Q. And would you agree that the number of cigarettes smoked today, the nicotine yield of the cigarettes and the number of pack years are related to the likelihood of an individual in stopping smoking?

A. I would agree that the more people smoke for the longer duration is a higher incidence of that person continuing to smoke. So, yes, in general that would be true.

Q. And --

A. I think that's true for any behavior, to be honest.

Q. So by 1980 Mr. Eastman had already smoked for over 35 years; right?

A. Let's see, yes, that's essentially correct.

Q. And you mentioned early in your testimony that if -- if people -- people wanted to smoke for nicotine, they would just go out and buy the gum or the patch

because you didn't think nicotine was all that addictive, is what you said?
A. I think the question was; "is nicotine the only reason or the main reason why people smoke?" What I said was, certainly part of the reason. But if nicotine was the only reason, nicotine was so powerful in terms of its effect on people, yes, I believe that two things would happen, that nicotine replacement

4007

therapies would be much more successful than they are. And No. 2, you would find some abuse of nicotine replacement therapies. And both those aspects are untrue.
Q. Well, if you took a glass of whiskey and you threw it down and drank it quickly, you would become intoxicated within a few minutes, wouldn't you?
A. Well, it depends. If you're used to drinking whiskey, no, you would have to drink a lot more and you would have to wait a longer period of time. But if someone was not a drinker at all and they drank one ounce of whiskey, I don't know if you would become intoxicated. You would probably have some psychoactive effects.
Q. Let's say 4 ounces, you just threw four ounces down.
A. Okay.
Q. Of whiskey, you would feel it within a few minutes, wouldn't you?
A. I don't believe in a few minutes. You might have some sensations certainly within, you know, 10 to 20 minutes you would start to feel drunk, sure.
Q. Okay.
A. Again, this is in a person who's not used to drinking that much.

4008

Q. If you take the same four ounces and you took one of those coffee stirrers, you know, they're like a little straw and you just sort of sipped it all day long, you might not ever feel it at all; true?
A. True, because your blood levels would be lower and your liver would be metabolizing the alcohol, so it may never reach the serum levels of causing intoxication.
Q. You mentioned crack cocaine smokers, they get that hit real fast to the brain, I guess in about 10 seconds?
A. I don't know the exact amount of time, but it is very quick as it is very quick for people that use IV heroin and crack cocaine, sure.
Q. Straight into the blood it goes straight up or you inhale it into the lungs and it goes right up to the brain?
A. It gets to the brain faster, that's true.
Q. Yeah. And you mentioned that cigarettes is 10 seconds for nicotine?
A. Approximately 10 to 15 seconds.
Q. Any faster for cocaine?
A. For crack cocaine, truth is I don't know, but it would be similar -- excuse me -- in that it would be relatively quick.

4009

Q. You think that if people just rubbed cocaine powder on their arm they would get that hit to the

brain?
A. No, I don't believe so. Unless they had a bleeding, gaping wound and they put it in there. But no, they would not.
Q. So a nicotine patch sort of wouldn't be the same thing, wouldn't it. You just wouldn't get that hit and maybe that's why people don't get addicted to nicotine patches?
A. Well, number 1, again, if nicotine was so pleasant, you're still achieving blood levels with nicotine, so there would be a feeling of enjoyment or pleasure out of any way of ingesting nicotine.
In addition, the types of replacement therapies vary. I think you and I have actually discussed this previously and using different routes you can achieve blood levels faster, not as fast as cigarette smoking, but the patches are slower than the gums. And the nasal inhalers have a faster blood level onset, especially Venus blood versus smoking cigarettes.
So as you get closer to a faster onset, you still don't see an appreciable improvement in either the success rate and you don't see people abusing nasal nicotine inhalers more than you do patches.

Q. Okay. Now, you mentioned that in your own patients, your own group of patients, I think you said you divide them into two groups, about half were motivated to try to quit and half weren't?
A. About half were significantly motivated to quit and about half weren't.
Q. And I think you said of those that were significantly motivated to quit, about half of them were able to quit.
A. No. Actually I think I said of those that were motivated and committed, about 75 percent were successful. And of the ones that were not motivated and committed, only about 25 percent were successful.
Q. So you -- the one -- I guess I didn't understand. The first group, let's say the ones that weren't motivated to quit, 25 percent of them were able to quit anyway?
A. Yes.
Q. Okay. So that left 75 percent of that group?
A. Approximately, yes.
Q. So approximately, what, 35 percent or so of the total?
A. Oh, you mean if we overall mixed it, again, I'm not exact on the numbers, but my experience is about 50 percent of people are successful, 50 percent are not.

Again, if we separate that into two groups, the ones that are motivated and committed, three-quarters are successful. The ones that are not, three-quarters are unsuccessful.
Q. And that's with the treatment program like you have?
A. I don't have a specific treatment program, but with the treatment protocols that I use, sure, that's my clinical experience.
Q. And over what period of time is that? Over what period of time is that treatment?
A. Well, it depends on the person and the treatments we use. If they're interested in a

combination, which is what I generally recommend of medications and behavioral therapies, I generally will use these combinations for a period of -- and medications for at least six to 12 months, because you get a little better response. And the behavioral therapies I ask them to practice them until they have success and continue some of those techniques in order to prevent relapse, I generally use a combination of nicotine replacement therapy and Zyban, which is an antidepressant medication that raises dopamine and various behavioral therapies.

Q. And during that 6 to 12 months, how often

would you see them?

A. In the beginning I might see them once a month, couple times a month. And then once they're fine, you know, once every three to four months. In addition, they can always call me if they have questions or concerns. And in addition, they're practicing on a daily basis, I hope, various behavioral techniques that I am suggesting. We try to get families involved to be supportive and encouraging. So even though they're not necessarily with me, I hope they are certainly utilizing various techniques to reduce the risk of relapse.

And to be honest, that's very similar in other types of behaviors that people come to see me for. I want them to take responsibility and to be actively involved, you know, in their treatment. That's the people that are successful.

Q. Now -- and you measure that for a year. I mean, is it like they have been off for a year, is that what you consider to be a success, somebody that is off for a year or is it just somebody that quits for a little a while?

A. With the numbers I provided --

Q. Yes.

A. -- the 75 percent, the successes, I would say approximately a year, maybe longer.

Here is why I'm answering it that way. A lot of people stop seeing me once they are no longer receiving their treatment. So I don't necessarily have feedback three years later or four years later. But based on my experience while I was treating them, while I knew them, I would use the amount of time of approximately a year. Some people would stop therapy sooner and some people will stay with me for a longer period of time.

Q. Well, did you mean the say that the 25 percent that were unable, didn't stick with the therapy for the 6 to 12 months that you prescribed?

A. Most of those people did not actively -- first of all, some of these people just said, "No, I won't try this, I won't take that. I won't do that." And some of them did some of those things but, again, kind of a halfhearted attempt.

Q. I'm just talking about the people that you said were motivated. I thought you said in the half that was motivated, 75 percent of them were able to quit, but 25 weren't?

A. Correct. I thought you were asking me questions about the half who were not motivated.

Q. No. The ones that were motivated.

A. Okay.

Q. 25 percent of those couldn't do it. They tried it for six months to a year with your therapy, and they couldn't do it?

A. Oh, I see what you're saying.

Q. Is that right?

A. Of those 25 percent of people that appeared motivated, who were not successful, the vast majority them never followed up for therapy after one or two visits.

Q. I think I just got a couple more questions for you, Doctor.

Those attributes, Mr. Eastman's personality characteristics that you showed up there, you know, that he was intelligent, that he was creative, that he was a smart guy?

A. Right.

Q. Would those apply to many of the people that you treat?

A. I would say all the people I treat have some of those personality characteristics.

Q. I mean, wouldn't most people say that their friend or their mother or their father is intelligent and decisive and strong willed and goal oriented and curious and resourceful and creative and independent. In fact, I'll bet you every military officer and every

chief petty officer and every first-class enlisted man in the service would probably fit this description, wouldn't they?

A. Well, I would certainly hope that a lot of them had those qualities, but let's go back to -- actually the first question you asked me, and that is, wouldn't everybody say this about their loved one, and this and that. And the answer is no.

When I interview family members and ask them questions about their loved ones, they will say positive things. They may say negative things. No, they will not give me that long laundry list of personality characteristic strengths.

Sure, some people have some of those. Some people have a lot of those. This is what people said about Mr. Eastman.

So to focus on Mr. Eastman in this case, this is what people said about him. And, again, I found these qualities very positive, and he could have used them to stop smoking if he chose to.

Q. One other thing here. You mentioned that you didn't see anything in the hospital records that -- well, first let me ask you, anxiety is a symptom of nicotine withdrawal; isn't it?

A. Anxiety is a possible symptom of nicotine

withdrawal. Anxiety is also a very common feeling that we humans have. And it certainly increases at times of stress, for example, being admitted to a hospital with respiratory problems. So it could be not smoking and it also could be related to his -- either medical condition or when people have COPD they are given beta agonists. They are given medications to expand their airways.

Well, one of the most common side effects of beta agonists is to feel very anxious and stressed and

tremulous. So it could be from several things.
Q. Oh, so you would know if he had nicotine withdrawal symptoms or not then?
A. No, that's not what I said.
Number one, he -- when I asked him he said he did not have withdrawal during the hospitalization. And I believe -- I may or may not be right on this -- I believe in his deposition he also said that he didn't.
And the other thing is if you look at the cluster of symptoms -- I mean, he described when he tried to stop at Smoke Enders, anger, irritability, anxiety, insomnia and a mild headache.
So it's not one symptom. It's a cluster of symptoms. So, you know, there to remains anxious and short of breath. All it means is that he was anxious. Possibilities is, sure, some of it could be from not

smoking, but I really would have expected a bigger cluster of symptoms much more common. You admit a person with COPD into the hospital, I mean, goodness, that's scary, they are in the hospital.
Number two, you are giving them beta agonists which stimulate peripheral beta receptors. And the feeling is tremulousness, anxiety, insomnia.
So I think that's probably more related to either the anxiety of being in the hospital or the meds and not withdrawal, because you should have seen a cluster of symptoms. He should have described it in his deposition. He should have described it in my evaluation.
Q. Didn't he say in his deposition or in his testimony that he was just too sick?
A. Yes, he said that. But I also -- when I was describing a sick person in the hospital with other substance dependency or abuse problems, you still see withdrawal problems, even though they are very sick medically in the hospital.
So, again, I just don't find evidence that he had significant withdrawal symptoms in the hospital. And I don't find evidence that the reason he didn't have them was because he was too sick or that he was treated medically so he didn't have them.

Q. He told you during your interview of him that he had significant withdrawal symptoms, didn't he?
A. I believe he described during that Smoke Enders attempt for the 24 hours and 26 hours that he told me about that, as I stated previously, he described anxiety and anger and some irritability and some insomnia, and I think he also said some mild headaches.
Q. Would you repeat those again. I just want to check them off.
A. Anxiety.
Q. Right.
A. Inability.
Q. Right.
A. Some anger, some insomnia and I believe mild headaches.
Q. Nervousness?
A. That's the same as anxiety.
Q. And he was cranky and he was disappointed and he felt like a coward?
A. Well, feeling like a coward or being

disappointed is not a withdrawal symptom, although that could have been his psychological response to not being successful.

Q. And he said he had an incipient headache as a result?

4019

A. Yeah, as I said, I believe he said he had a headache.

Q. And he said he didn't sleep?

A. And as I said, I believe he said he had some insomnia.

Q. And when -- I think when you testified a year or so ago I think you had said you made about $125,000 testifying for the cigarette companies up to that point?

A. Well, I believe what I said was over the years that I have been consulting on these cases and it's been -- and I may not be accurate on the exact amount, but I think it's been seven or eight years of involvement, I charge for my professional services, my time. I charge $300 per hour for forensic work. And, yes, over the years that's approximately over all the years how much I billed at that time.

Q. And normally you -- you spend 50, 60 hours on a case?

A. It depends on the case. I certainly spent a lot more time on this case because there was so much information and the IME was so long and there was so many depositions and medical records. So this case actually took a lot more of my time than other cases have.

Q. A 100 hours?

4020

A. Oh, no, no, no. I haven't put together the hours, but I probably put somewhere in the range of 40 hours or so, 30 to 40 hours.

Q. And additional time today?

A. Yeah.

Q. Are you including that?

A. In there, yeah, 30 to 40 hours.

Q. Okay. So 30, 40 hours at $300 an hour would be, what, between 9 and $12,000?

A. Yes, sir.

MR. ACOSTA: That's all I have. Thanks.

THE COURT: Anything else?

MR. LYDON: No questions, Your Honor.

THE COURT: All right. You may stand down. Thank you very much.

THE WITNESS: Thank you.

THE COURT: Anything else from the defense at this stage?

MR. LYDON: Your Honor, can we approach.

THE COURT: Yes.

(Proceedings at the bench follow.)

MR. LYDON: I think we are at the end of our testimony. I just wanted to double-check before we rest.

MR. ACOSTA: What's that mean over lunch?

4021

MR. LYDON: Yeah. I think probably after lunch. I just want to make sure.

THE COURT: I would like to send the jury home, you know what I mean?

MR. LYDON: Maybe take five minutes.

THE COURT: Do you have something else?
MR. ACOSTA: I just have two exhibits to put in. The one -- two -- one is Farone's drawing, and the other is that portion of the brochure that I showed yesterday that I passed around to the jury, just those pages.
MR. WALLACE: And I have Groff's records DC and biology reviews that Dr. Blackie spoke of that I need to move in as well.
THE COURT: Well, I guess what we could do is tell the jury that they can go home and come back tomorrow and we are going to complete the case tomorrow morning. And there might be some additional items of evidence, but basically we would be starting in the morning with closing remarks and instructions, unless you want to try to figure something out right -- I just don't want to say you have rested.
MR. LYDON: Nor do I.
MR. ACOSTA: I think that would be fine,

Judge.
THE COURT: Okay.
(Proceedings in open court follow.)
THE COURT: All right, ladies and gentlemen of the jury, we are about to the conclusion of the presentation of evidence. The parties are not resting technically at this point because there might be some other items of evidence which might be introduced. But for the purposes of your work, your day is done. I'm going to let you go home today. At this time I'm going to request that you come back and be ready to go at 9 o'clock tomorrow morning. We anticipate if there are additional documents or items of evidence to be introduced we will do that in the morning and we will certainly commence our closing arguments to you and our instructions to you and deliberations will begin probably tomorrow afternoon.
So have a nice afternoon. It's a beautiful day, and we will see you tomorrow at 9:00. Please remember the cautions that I have given you about not discussing the case. Continue following that.
JUROR: Is this A April fool's joke.
THE COURT: No, this is not a joke. This is for real. You get to enjoy the day.

(The following took place out of the presence of the jury.)
THE COURT: And I think perhaps we will take a longer lunch than we ordinarily do. We will -- I will meet with you back here at 1:30 and we will talk about loose ends and instructions. Okay.
(11:51 a.m. A recess was taken, after which the following proceedings were had:)

CERTIFICATE OF REPORTER

STATE OF FLORIDA)
COUNTY OF PINELLAS)

I, BETH L. BILLINGS, RPR, Deputy Official Court Reporter, in and for the Six Judicial Circuit, State of Florida:

DO HEREBY CERTIFY that the foregoing proceedings were had at the time and place set forth in the caption thereof; that I was authorized to and did stenographically report the said proceedings and that the foregoing pages, numbered 3899 through 4024, inclusive, is a true and correct transcription of said stenographic report.

IN WITNESS WHEREOF, I have hereunto affixed my official signature and seal of office this 1 day of April, 2003, at St. Petersburg, Pinellas County, Florida.

_____
BETH L. BILLINGS, RPR